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Chamberlain, Marie

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by

Marie Chamberlain

Thesis submitted for the degree of Ph.D
University of London
King's College London
May 1993

CONTENT

ABSTRACT

Factors affecting the Acquisition of Skills in Midwifery Students

This study used a qualitative, ethnographic case study design to identify how student midwives acquired clinical skills and knowledge. Student midwives were observed and interviewed in a large urban maternity hospital in England to ascertain how they obtained their clinical skills. The study took place over an eighteen month period and involved observations in all hospital clinical settings and the community. A cohort of twenty-five students was followed with five student representatives from five different sets. Two sets were followed from the beginning of their training, two from the early to middle stages and one to the completion of the training programme. Midwifery managers, teachers and midwives were also interviewed.

Themes which emerged from grounded theory analysis suggested that the greatest and most pervasive influences on students' clinical competence were communication between midwives and students, students' previous socialisation to nursing, the socialisation practices of the hospital and the anxiety engendered by the clinical areas. Other influences were the midwifery teaching styles and motivation to teach, medical interventions and students' learning styles.

Limited organisational support for the student and professional midwifery role resulted in some midwives seeking to control interactions with students and clients through the use of various communication strategies. This effect was compounded by midwives who had adopted the bureaucratic values of the organisation at the expense of the values of their profession. These midwives sought to restrict students' learning through the control of information. The professional socialisation provided by the educators was reduced and in some instances, destroyed, by their lack of support of student midwives in the clinical area and their legitimation of the student role. The lack of support provided by some managerial midwives for professional decisions on client care has led some midwives not to question the status quo.

ACKNOWLEDGEMENTS

To Brian Davies, thesis advisor, whose continual guidance, support and timely use of humour made this thesis possible.

To Marcia Smith who provided support and assistance in the difficult times.

To the students who tolerated me during difficult periods and gave unstintingly of their time and support.

To Sarah who continued to encourage me despite her own difficulties.

To the service and education staff involved in this study who provided me with the impetus to continue

To my parents without whom none of this would have been possible.

To Louise Clement and Michele Mongeau who volunteered their free time and expertise to assist me in the completion of this document.

To my colleagues, for being there.

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CHAPTER ONE

INTRODUCTION

From its earliest recorded history the rise and fall of midwifery in Britain has been associated with women's economic relationship to the state. The capacity of women to reproduce healthy and productive citizens has been the single most important stimulus for government involvement in reproductive care. Government intervention was much later than it should have been and this has been blamed on the traditional mistrust for state control. This mistrust had arisen as a result of the early domination of parliament by the ruling classes (Lewis, 1980).

Attempts at control of maternity care by the medical profession have been successful because of the government's lack of interest in maternity care. Control was sought by the doctors as a way to reduce competition from midwives and to raise their own status within the medical profession and the public (Lewis, 1980). This has been so successful that maternity care is still to a certain extent controlled by the medical profession through medicalisation and policies governing midwives' practice.

The historical perspective presented here is not intended to provide an inclusive review of the historical evolution of midwifery. It is written from a researcher's perspective and identifies evolutionary decisions in maternity care thought to affect the practice of the present day midwife. It is considered to be important because the midwife's practice will have an impact upon the students with whom she/he comes into contact especially if she/he is responsible for their clinical education.

1.0 An Historical Perspective

Earliest references to midwifery as an occupation were recorded in the first books of the Bible. In Genesis, chapter 38 verse 27, it is written 'When her time was come, there were twins in her womb and while she was in labour one of them put out a hand. The midwife took a scarlet thread and fastened it around the wrist, saying "this one appeared first".' Subsequent references refer to assisting a woman in labour and the King of Egypt's attempt to use midwives to control the Hebrew population through infanticide (Genesis 35, verses 17-18; Exodus 1, verses 15-18).

From earliest times the practice of medicine and midwifery was open to all, male and female, educated or illiterate, though women tended to cultivate the healing arts while men hunted for food or were away at war. This situation continued until the advent of the thirteenth century when a form of occupational regulation began with the development of barber-surgeon guilds, an early precursor of the British Medical Association. Members of the guild were granted the exclusive right to practise in their location in return for certain guarantees that they would maintain standards prescribed by the guild. Along with the protection of their practice, guild members also received the sole right to the use of surgical instruments. Some of the barber-surgeons began to concentrate on maternity cases which required their instrumentation and became known as man-midwives. This form of regulation had important repercussions on midwives practising in guild areas as they were now required to call in guild members for obstructed labours for which instruments would be required (Donnison, 1977).

1.1 Demise of Midwifery

The Renaissance hastened the demise of the midwives' stature within the community. The prevalent spirit of enquiry encouraged the development of medical sciences, such as anatomy, encouraging doctors to become more interested in child birth. Work by Ambroise Pare provided an understanding of the mechanisms of labour and with the new advances men began to enter the childbirth field and compete with the female midwives for clients. With the introduction of forceps by the man-midwives in 1720, female midwives found themselves excluded from their wealthier clients who wished to shorten their labours through the use of such instruments (Donnison, 1977).

An additional effect of the Renaissance was to reduce the influence of the church with the general population. This had a negative effect on midwifery because of the church's role in the regulation of midwives. The church had to certify that all midwives were of good character and this certification lent status to the occupation. With the churches' declining influence on moral issues well educated women did not perceive midwifery as an appropriate occupation and this led to a drop in the standards of practice.

The emergence of the lying-in hospitals in the eighteen century meant that man-midwives, often excluded from assisting with births which did not require the use of instruments, had access to women for normal deliveries. This provided the man-midwives with an expertise in normal deliveries which they had previously lacked. Women who were poor

were often admitted solely because of their poor nutitional state. These women were often the clients of the midwife and this admission further deprived the midwife of previously available clients (Roberts, 1981).

The advent of the evangelical movement further reduced the fortunes of the midwife because of the attack on words which were not considered 'respectable'. Such a word was 'midwife' and this along with words, such as 'sex' and 'reproduction' could only be referred to in an oblique fashion. Along with the restrictions in language came a restriction in women's activity. Women were now expected to stay in the home and such societal constraints prevented educated, middle class women from entering into midwifery. The ban on the use of 'non respectable' words prevented the female midwives from being able to use any influence that they had with powerful men to improve their status.

With the reduced status of the female midwife the man-midwife was able to make further incursions into maternity care. These men kept the use of the forceps to themselves and this, along with the lack of education for female midwives in the lower classes, aided the man- midwife's popularity with labouring women. To increase this popularity and decrease competition they further denigrated the practice of the female midwives and blamed them for problems occurring in childbirth. They exaggerated the problems of childbirth and frightened women into believing that only they and their instruments could save them. As a result, the few midwives who were educated were too weak and too overworked to organise against them. The lack of a formal midwifery society or journal prevented any formal efforts that might have been made to refute the charges (Roberts, 1981).

1.2 Early Midwifery Education

Until the end of the seventeeth century midwives had required only personal experience of childbirth to practice. All that had changed with the advent of the man-midwife. Men were educated while women, particularly those of the lower classes found it difficult to obtain education in any form. However, advances in education began to be made in the nineteenth century as a result of the women's movement. Women's colleges were established and in 1878 after much opposition, women were allowed to obtain a degree from the University of London. With these educational opportunities came the invasion of medicine by women. The medical profession, hostile to the invasion, now determined that midwifery was a respectable profession and was the ideal type of profession for such women to enter (Donnison, 1977).

Midwives began to recognise that to improve their status they must be educated and maintain certain standards. In their efforts to ensure they became educated and independent they sought legislation which they felt would enable them to practice without medical control. A previous attempt at legislation in 1616 by a group of well-educated midwives and Peter Chamberlen of the forceps family had failed due to midwifery and medical opposition. The midwives feared the monopoly which Peter Chamberlen sought over the licensing, instruction and attendance at difficult cases. The medical profession felt that licensure would elevate the midwives to a level they did not deserve and they were also suspicious of Chamberlen's motives (Baly, 1986).

Industrialisation and urbanisation initiated a period of great change in eighteenth century Britain. Industrialisation brought increased prosperity and a resultant increase in population. Despite this increase there were many concerns about depopulation particularly of the middle classes for it was not until 1788 that births exceeded deaths. The status of midwifery declined further in this period of increased affluence when more people were able to afford the fees of a doctor. With the advent of forceps more medical men entered midwifery and this excluded midwives from their wealthier clients who wanted the forceps to shorten their long and tedious labours. Forceps also had the potential to deliver more live infants, a fact which many of the medical men emphasised (Donnison, 1977).

Scotland like most of Europe was more advanced than England in midwifery education. In England midwifery education was still in the hands of the voluntary charities which ran the lying-in hospitals, while in Scotland the city of Edinburgh had hired its first professor in midwifery. In 1726 the city also strengthened a previous law which dealt with midwifery regulation. The city of Glasgow was not far behind and in 1740 their faculty of physicians and surgeons instituted a system of midwifery licensure and examinations. Scotland became the first country in Britain to provide midwifery training and trained 1,000 midwives between 1780 and 1818, four times the number produced by British lying-in hospitals over the same period (Donnison, 1977).

It was the opening of the British Lady-in-Waiting hospital in 1830 that heralded a new concept in maternity care in England. The hospital's aim, under the patronage of Sir Anthony Carlisle, was to provide well-trained midwives for the rich and poor. Midwives received instruction from a consulting midwife, Mrs Beale, who had attended patronesses

of the hospital, one of whom was Queen Victoria's mother. However, by 1848 a surgeon-accoucheur had replaced the consulting midwife which limited the provision of midwifery education to the medical profession. In 1926, at the instigation of the medical profession, the hospital established courses for monthly nurses. These were nurses who assisted the doctor during the delivery and nursed the mother for the lying-in period. By the 1940's and 1950's the hospital was training three times as many monthly nurses as midwives. The monthly nurses and the doctors were in direct competition with the midwives for the wealthier clients (Roberts, 1981).

In 1841 Dr William Farr, Statistician Superintendant at the Registrar General's Office, spoke out against the lack of midwifery training. He suggested that well-educated and trained midwives would reduce the the high maternal mortality and morbidity rate. However, it was not until Florence Nightingale's entry into nursing with the corresponding improvement of status for that profession that education for midwives was deemed to be appropriate. After the Crimean War a grateful public was persuaded to empty its pockets for the Nightingale Fund. Money from this fund was used by Florence Nightingale in 1862 to establish a midwifery training school at King's College Hospital. Unfortunately, for a variety of reasons the midwifery school was closed 6 years later (Donnison, 1977).

The training programme for midwives instituted by Florence Nightingale required six months. This was strange as Miss Nightingale had long supported the European custom of a two year training programme for midwives. What was not clear was whether the midwives trained after they had completed a two year nursing course. This would be somewhat similar to the present time where the majority of midwives train in midwifery after completion of a three year nursing programme. At the same time as Miss Nightingale's midwifery training programme was one started by Doctor James Edmund in a college in West London. Pupil midwives were given two winter lecture sessions on midwifery and the diseases of women and children. Summers were spent obtaining experience in lying-in hospitals or charities. New graduates were able to compete with doctors and obtain comparable fees for maternity care (Baly, 1986).

In 1869 the Obstetric Society investigated the causes of high infant mortality and blamed it on inadequately trained midwives. As a result it established an examination for midwives with diplomas for those who were successful. With the Society's new official recognition as part of the medical profession, it sought to consolidate its position by extending its control over midwives. Although previous attempts to regulate midwifery had failed due

to medical opposition the obstetricians began to recognise that if they wanted to control midwifery it would have to be through regulation. Through regulation they would be able to ensure that midwives cared for the poor while they kept the wealthier clients for themselves. To this end they proposed a scheme for midwifery regulation which was withdrawn before the final reading in parliament largely as a result of members of parliament who supported the midwives. However, the obstetricians were successful in apportioning the blame for high maternal and infant mortality to midwifery negligence. A report from the Select Committee of Parliament in 1893 stated that the cause of the problems was the inefficiency and incompetence of midwives (Donnison, 1977).

1.3 Midwifery Regulation

The midwives had been active during this time and their fortunes had started to improve as a result of the women's movement. They had finally managed to organise themselves into an association with Maria Firth, a midwife and matron of the British Lying-in Hospital, as their president. They now used this association to seek regulation and to fight against medical control. In their fight to register midwives, they sought out influential men who were sympathetic to their cause. One such man was James Stanfield, president of the local government board and a member of the women's rights movement. An additional factor which aided the midwives' movement was that there was an estimated quarter of a million more women than men in the 20 to 40 year age group. This meant that with few marriage prospects women could not stay home, especially if there was little money, but had to venture out and join the workforce. Now, because of economic reasons, it became respectable for women to seek education and enter the occupation of midwifery.(Donnison, 1988).

The demise of the Midwives' Association eight years after its formation was followed in 1881 by the formation of the Matron's Aid which was the precursor to the Royal College of Midwives. The Matron's Aid was formed by Louisa Hubbard with the assistance of three influential midwives. Louisa Hubbard was not a midwife but was a woman of influence who had formed a society for the employment of women in 1859. Recognising the need to counteract medical opposition if they were to have any success with midwifery regulation the Matron's Aid declared that midwives were competent to deal only with women with a 'natural' labour and that medical assistance would be required for those women who did not meet this criterion (Donnison, 1988).

The first educated female doctors, Anderson and Blackwell, opposed the college as they felt midwives were not fully qualified. Feminists of this period sided with the female doctors as they perceived them to be more oppressed by the male medical profession than the midwives (Ehrenrich and English, 1972). This created even more isolation for the midwives who were also beginning to find themselves in opposition to the nurses over regulation and registration. In 1887, Mrs Bedford Fenwick and a group of nurses founded the British Nurses Association. A long time campaigner for nurses registration, Mrs Fenwick approached the Midwives' Institute, formerly the Matron's Aid, to join forces and proceed together in their efforts towards regulation through parliament. She was rebuffed by the Institute partly because they felt their case was more advanced than that of nursing and partly because they felt that nursing was not an independent profession like midwifery (Donnison, 1977).

The Midwives' Institute had embarked earlier than the nursing profession on a campaign to gain parliamentry support for midwifery regulation. It was an opportune time because the government had deemed it not only appropriate but necessary to intervene in maternity care. The Boer War had provided the stimulus for government involvement when forty-eight per cent of the recruits had to be rejected on physical grounds. This, along with fears of the depopulation of the middle classes, ensured that government would intervene and support the idea of midwifery regulation if it led to a healthier nation (Levitt and Wall, 1984).

The Medical Reform Act of 1886 required all medical practitioners to have midwifery training which placed midwifery in the realm of medical specialisation. This increased the number of attempts by the medical profession to gain control over midwifery, particularly in the area of education. As early as 1872 the Obstetrical Society had requested money from the Nightingale Fund to set up its own examinations for midwives providing a certificate to those who were successful. However, no money was forthcoming because Miss Nightingale saw no point in an examination without the provision of midwifery education (Baly, 1986).

The Midwives' Institute fought long and hard to get a bill into parliament for midwifery regulation. There was much opposition from the medical profession as well as other midwives who felt that the Institute's philosophy was at odds with the realities of midwifery practice. They also opposed the Institute's decision to place midwives at a lower level than doctors in order to get the bill past the medical profession. The first

midwifery bill to be introduced to parliament in 1890 placed midwives under medical control. The formation of a Central Board was written into the bill to regulate midwifery. The members would consist of obstetricians from London teaching hospitals and other medical personnel. The only concession made to the Institute was to allow them one representative on the Board. Various adaptations to the bill were made at different stages but it failed when it was opposed by members of parliament who felt it discriminated against women (Donnison, 1977).

Several more attempts to guide bills through parliament failed as a result of medical opposition supported in some instances by the Nurses Association. As a result the Midwives' Institute determined to embark upon an open campaign to obtain public support. A second bill was introduced which kept midwives under medical control and lost them their sole representative on the board. During the bill's passage it was adjusted to place midwives under a central board and the clause restricting midwives to normal labours was removed. Parliament fell before this bill could be enacted.

With the failure of the bill of 1893, an anti-midwifery movement began which was fuelled by the medical profession and supported by nursing. The British Medical Association supported nursing registration while condemning it for midwives. However, the midwifery movement had gained strength over the years and now had ten local branches and a membership of 2000 amongst women of all classes. Three more bills were introduced into parliament, one by the British Medical Association for the registration of obstetrical nurses, but all failed. It was not until February 1902 that the first successful Midwives Bill was introduced into parliament. It received a favourable passage despite medical opposition (Donnison, 1977).

1.4 Midwives Act 1902

Under the new bill annual licensure requested by the medical profession was dropped in favour of Notification of Intention to Practice, still present in the most recent Act of 1979. A Central Midwives Board was created independent of medicine and and formed and controlled by the Privy Council. The Home Office and the Local Government Board were largely responsible for these changes to the Act because they felt that midwives' regulation was a matter of public interest and finance and therefore belonged to the government. The bill became law ninety years after the first proposals for midwifery regulation (Donnison, 1977).

While the passing of the bill represented a setback to the medical profession they were still able to obtain their objective of midwifery control in other ways. Even with the legislation which brought about the formation of a Midwives Board, midwives were still not in control. Only one midwife was allowed to be on the board and the majority of board members were made up from the various bodies of the medical profession. The Board controlled the functioning of midwives by setting educational and practice standards. It took approximately seventy years before a midwife achieved the distinction of serving as the chairman of the Board.

Under the 1902 Act, midwives were required to take an approved three month training course and pass the Board's exams before they could call themselves midwives (Robinson et al, 1988). In 1904 the role of midwives was further boosted when the Committee on Physical Deterioration published its first report. Formed after the recruitment problems of the Boer War, the majority of its report was devoted to infant welfare. The Committee recognised that it was in the national interest to ensure healthy infants to improve the quality of the race (Lewis, 1980).

In 1919 the Board of Education gave a boost to midwifery education when it provided grants for pupil midwives who expressed an interest in practising midwifery. This 'generosity' had been stimulated by the Maternal and Child Act of 1918 which required local authorities to provide salaried midwives as part of their maternity services (Lewis, 1980). Many midwifery schools are now requesting such grants for students in place of salaries as there is a recognition that salaries have created a situtation where the student has been required to provide service at the sacrifice of education.

Between 1910 and 1916 local governments began to issue reports on infant mortality. Later reports were to include maternal mortality and and local government efforts to improve infant welfare. At this time child and maternal welfare was measured exclusively in terms of mortality and government policy became focussed on the treatment of mortality as a medical problem requiring medical treatment and not on the underlying socio-economic causes. One of the results of this policy was that the medical profession gained influence with the government on the formulation of policies for maternity care (Lewis, 1980).

1.5 The Emergence of National Maternity Services

With the advent of World War One came a recognition of the relationship between maternal welfare and fetal and neonatal death. The care of the mother became incorporated into health services as part of a campaign to decrease infant mortality and this care was extended into the antenatal period. Recognition of this fact had arrived earlier in Edinburgh where the first antenatal bed had been endowed in 1902. In 1918 the Child and Maternal Welfare Act required all welfare authorities to set up committees and provide full maternity services. Part of those services was the inclusion of salaried midwives.

The emergence of midwifery as a 'respectable' occupation has been linked with the development of maternity services and better care for women. After the Midwives' Act midwifery began to change in function from a person who was 'with woman' at childbirth to a person educated and trained to understand the requirements of a woman, fetus and infant in pregnancy, labour, delivery and the puerperium (Bent, 1982).

1.6 Maternal Mortality and Health

In the years prior to World War I the medical profession and the policy-makers had concentrated their attention on the problem of infant mortality. It was only with the decline of the infant mortality rate that attention was directed towards the mortality rate of mothers, a rate which had continued to increase, largely as a result of puerperal sepsis. Between 1923 and 1936 (there were no reports on maternal mortality prior to this) maternal mortality was the only major cause of death to show an increase. The publicity this gave the goverment was particularly embarrassing in the light of their efforts to increase the birth rate (Lewis, 1990).

May Tennant, a former Inspector of Factories and wife of a Liberal MP, joined forces in 1927 with Gertrude Tuckwell, a leading trade-unionist, to form an unofficial maternal mortality committee. They not only lobbied the government on maternal mortality but also raised the issue of maternal morbidity. They became such an annoyance to the government that the Ministry of Health expressed irritation with the way their mortality figures had been used to generate publicity for women in order to achieve better maternity care (Lewis, 1990).

The emphasis placed on the medical causes of maternal death meant that attention was focussed exclusively on abnormal pregnancy and parturition. Obstetricians used this emphasis to advance their speciality. Concentration on labour abnormalities led to the use of rigorous asceptic techniques where women were treated as if they were to undergo a major surgical procedure rather than a natural event. Pregnancy increasingly was equated with illness and its management became increasingly medicalised. This trend favoured the introduction of general practitioners, despite their lack of maternity training, to care for pregnant women and to attend births which took place in the woman's home (Graham and Oakley, 1981).

The British Medical Association (B.M.A.) felt threatened by midwives who still played a major role in community childbirth. They felt that the general practitioner, despite his lack of obstetrical training, should provide antenatal care to pregnant women and should be the person to decide on whether a pregnancy and parturition were normal. One interesting point to note is that this issue was fought from a platform of continuity of care. The B.M.A. was also feeling threatened by the medical officers of health who worked in the municipal clinics and who they felt were taking antenatal care from the G.P's, care which they stated should only be provided by midwives or G.P's. Another concern of the B.M.A. was that if midwives were trained in antenatal care it could adversely affect women seeking out their general practitioner. They would seek out the midwife instead and the G.P would lose his\her connection with the family. What the medical profession failed to recognise was that an aversion to medical examination by male physicians was a major factor in the poor uptake of antenatal care (Graham and Oakley, 1981).

The efforts of the B.M.A on behalf of its members paid off. In 1930 the report from the Committee on Maternal Mortality and Morbidity assigned the central role of community maternity care to the general practitioner. The Committee's plans became incorporated into the government's scheme for a national maternity service. The emphasis on medical attendance in pregnancy led to a closely defined hierarchical relationship between the doctor and the midwife. The measure of a good midwife became the number of times she called for medical assistance (Lewis, 1980).

1.7 Antenatal Care

The Maternity and Child Welfare Act of 1918 provided the impetus for the funding of maternal and child welfare services whether they were performed by voluntary

organisations or through hospital services. Such services usually included those provided by a salaried midwife as well as the services of health visitors and antenatal clinics. The initial problem in organising antenatal clinics was the identification of women who were pregnant and would benefit from such clinics. At this time 95% of women booked with a midwife when they became pregnant and therefore the midwife was the key person for the information required by the clinics. In some areas the midwives were instructed by their Local Health Committees to notify all their bookings to the Medical Officer of Health, while in other areas a voluntary notification by the midwife or the G.P was instituted if the woman provided her consent. By 1918 there were 120 antenatal clinics run by local authorities for working class women to be 'medically supervised' (Oakley, 1986).

Voluntary groups were at their most powerful in the field of public health during the years between the two wars and they provided infant and maternal health services in many areas. One of the most notable was The National Birthday Trust run by Lady Rhys Williams who was also secretary of the Joint Council of Midwifery which helped to establish the 1936 Midwives Act. She believed that the two most important factors for maternal health were a good well-trained midwifery service with specialist backup and adequate nutrition for pregnant women (Peretz, 1990).

By this time there was general agreement in the medical profession, the Ministry of Health and voluntary organisations that that there should be a national maternity service based on home deliveries by midwives and backed up where necessary by G.P's and obstetricians. Midwives would also provide the majority of the services for the antenatal clinics. However, there were differences in opinion as to how many births should take place in the home, but essentially home births were to provide the structure for the service.

Two reports published by a Departmental Committee on Maternal Mortality and Morbidity suggested that a lack of antenatal care was implicated in 33% of avoidable deaths and a lack of facilities or professional judgement in 50% of maternal deaths. The reports went on to suggest that while all mothers should be cared for by a registered midwife they should all be examined antenatally and postnatally by doctors.

It is not clear at what stage nurses began entering midwifery or when a midwife who was also a nurse became preferred to a midwife who was not. Nursing had also been expanding and diversifying during this time particularly in different areas of hospital care. In 1919 the Nurses Registration Act was passed which established the General Nursing Council as

the regulatory body for nurses. By 1926 there were 56,000 nurses working in hospitals in Britain (Maggs,1987). However, the majority were female because men were not incorporated into the main nurses register until 1939 and were not admitted into midwifery until 1975 after the passage of the Sex Discrimination Act.

By 1936 policy makers had determined that the ideal education for a midwife was one which followed a nursing training because it provided an improved quality of care. However, it has been suggested that this policy represented the end of midwifery which had previously concerned itself with the 'normal' processes of reproduction (Oakley, 1986). Adding nursing with its 'illness approach' was perceived to be supporting the medicalisation of reproductive care. The autonomy of the midwife was also dealt a blow by the Midwives Act of 1936 which established a salaried midwifery service under the control of local authorities. While a salary was welcomed by many midwives who were having financial difficulties maintaining a practice due to the incursion of the G.P. into obstetrics, few realised how much their independence would be eroded by such a move. Further erosion was to occur with the introduction of the National Health Service which contained 'no clear-cut account of the midwives part in the service' (Cowell and Wainwright, 1981).

The Midwives Act of 1936 also had a positive effect on midwifery because it became mandatory for local authorities to ensure certified midwives were available for home births, a statute incorporated into subsequent acts (Bent, 1982). The Act also facilitated the work of the midwife into antenatal care and accelerated the provision of analgesia for use in domiciliary midwifery (Donnison, 1988).

In 1919 the new Ministry of Health was established and in 1923 Doctor Janet Campbell, senior medical officer for the Ministry, was asked to investigate the training of midwives. Her report recommended an increase in training to twelve months for non-nurses entering midwifery. She also advised a curriculum revision to include ante and postnatal care and clinical and theoretical instruction in labour management in hospital and the community. An additional recommendation was the establishment of a teaching certificate in midwifery as she felt the current curriculum did not include the principles and practice of teaching and learning (Campbell, 1923).

The members of the Central Midwives Board (C.M.B.) were in agreement with Doctor Campbell's recommendations and the curriculum was revised in 1926. At the same time

training was increased to one year for direct entrants with six months remission for nurses. A departmental committee was formed by the Ministry of Health three years later to review the Midwives Acts with reference to the training of midwives. They recommended inspection and approval of training schools and three months supervised practice after training. An additional recommendation was for compulsory examinations for midwives wishing to teach and the organisation of post-certificate courses (Robinson, 1990).

In 1930 the C.M.B again revised the curriculum and extended the training period to two years for direct entrants with a one year remission for nurses. The training for nurses was divided into two components with the first six months spent in the hospital, and the second six months either in the community, or three months in the community and three months in the hospital. It was thought that this measure would reduce costs incurred by nurses who trained in midwifery for career purposes or health visitors who required part I before they could enter their programme. It also provided nurses with the opportunity of deciding whether they wished to continue with a midwifery career (Donnison, 1977).

One of the interesting aspects of this period was the high proportion of home births. Pupil midwives training during this time were required to have attended at least ten home births in order to qualify as a midwife. This stipulation had to be removed in the late 1960's because of the lack of home births available for midwives to attend. The decrease in home births was the result of an emphasis on the medicalisation of birth in the Ministry of Health reports which questioned the appropriateness of the home as a place for birth. These reports also called into question the competency of midwives and general practitioners who attended home births. The G.P's had little and the midwives had no representation on departmental commitees at the Ministry and were therefore unable to defend their positions. The long term result became the hospitalisation of almost all births (Lewis, 1980).

By 1935 Dame Janet Campbell was supporting the hospitalisation of all women with abnormal pregnancies and all women with their first pregnancy. A strong supporter of the midwives at the Queen Jubilee Institute she felt all normal births should take place in the home. However, a debate arose over the use by midwives of analgesia and anaesthesia for home births. A report from the College of Obstetricians and Gynaecologists stated that chloroform capsules used in hospital births were unsuitable for home deliveries. The evidence used to support this was one death which occurred out of 2,380 deliveries and this death was caused by a medical student. The College did allow midwives to use gas

and air but only if they had been trained in its use. However, the cost of the equipment was prohibitive to most midwives so that few were able to take advantage of this method of pain relief (Donnison, 1977).

1.8 The Hospitalisation of Midwifery

World War II accelerated the move of pregnant women to hospital for childbirth. There was an increased demand by women for hospital beds because their men were away fighting in the war and other family members were involved in war work. Many midwives had to be used as nurses to care for war casualties and this led to a dearth of midwives in the community for home births, especially in rural areas. This process was circular as the shortage of midwives also created a further demand for hospital beds and a shortage of community clients led many midwives to seek positions in the hospital where they could be assured of a salary (Bent, 1982).

The creation of the National Health Service has been identified with the end of independent midwifery practice because of its provision for salaried midwives in hospitals. Regular hours combined with a regular salary encouraged many midwives to seek employment with hospital authorities, although some preferred to remain in domiciliary practice which also conferred a regular salary but not regular hours. Such a choice was possible because under the Act, maternity services were to be provided by all three branches of the N.H.S: the hospital service, domiciliary services and services by general practitioners (Robinson, 1990).

The formation of the N.H.S came about partly as a result of the Beveridge Report on Social Welfare Reform. This report led to government negotiations with people involved in health care with a view to creating a Health Service. Unfortunately, midwives were not a group who had power with regard to negotiation and the 1944 government white paper on the proposed N.H.S contained no defined role for the midwife in the future service.

In 1946 the National Health Service Bill was published and in 1947 the N.H.S was created. The N.H.S. Act changed all local authorities to local health authorities and they became responsible for medical aid at clinics. A profound and far reaching result of the Act for midwives and G.P.'s was that general practitioners were to be paid a special fee for providing maternity care. In addition there was a substantial increase in the the number of obstetrical registrars in hospitals and in the establishment of departments of obstetrics. The

ulimate outcome of such measures was the regionalisation of maternity care and the closure of many small maternity units in cottage hospitals which had been staffed by midwives and G. P's and catered to women with low risk pregnancies.

With this Act the last of the 'bona fide' midwives retired and only qualified midwives were employed (Leavitt and Wall, 1984). The profession of midwifery was taken over by the N.H.S. and midwives became employed on the same basis as nurses. Once they became salaried, midwives were required to follow policies initiated by their local health authority or employing hospital and these usually restricted their previous independence with regard to making decisions in midwifery care (Donnison, 1988).

The N.H.S Act had a profound effect on midwifery because the special fee paid to G.P's for maternity care encouraged more G.P's to provide maternity services. Women who attended their G.P for care other than that required for pregnancy tended to go to them for a confirmation of pregnancy instead of going to their midwife. Once the pregnancy was confirmed, the G.P encouraged the women to continue with him/her for their antenatal care. As a result many midwives did not see their clients prior to being called to the delivery of the baby.

One of many reviews of midwifery practice was made in 1947 by a government Working Party chaired by Baroness Stocks. This group made a total of 62 recommendations some of which are only now being implemented. Among the recommendations was a basic training for nurses and midwives to be followed by specialisation in one of the areas. This is now the focal point of Project 2000 formulated by the United Kingdom Central Council and accepted by nurses but rejected by midwives. The Working Party also reiterated that there were differences between nurses and midwives and although midwives required a thorough knowledge of many nursing skills, it was not necessary or desirable for a midwife to also be a nurse. This was because a large part of the training of a nurse was spent caring for the sick while the midwife cared for healthy childbearing families.

Other recommendations were, that male nurses should witness deliveries and receive instruction in obstetrics, an area from which they had been barred, and pupil midwives should be given student status and a reduced work week. Neither recommendation was implemented before 1970 with student midwives working an average of forty eight hours per week until 1968. A final important recommendation was that midwifery training should not be divided into two parts (Bent, 1982).

As a result of the recommendations the midwifery teacher's course was reviewed and extended to one year in 1971. A recommendation that students should be taught institutional, domiciliary and abnormal midwifery was implemented in 1976. While pupil midwives were eventually awarded student status in the 70's the change was in name only and did little to alter their circumstances. Not only were they not provided with the grants recommended by the Stock's Report but they were also not provided with the educational status inherent with being a student. As a result student midwives continued to be used to provide service with little emphasis on their educational requirements and still are as noted in this study.

In 1968 the two part system for training midwives became one year. With the increasing use of technology and specialisation in maternity care the Central Midwives Board quickly recognised that one year was inadequate for the training of midwives and felt that an increased training period would cut down on midwifery wastage. But it was not until 1981 that the programme was increased to three years for direct entrants with eighteen months remission for nurses. This increase in training appears to have had little effect on the retention of midwives (Robinson, 1986).

The Briggs Committee, formed in 1972 to report on midwifery and nursing, recommended a joint regulatory body for the two professions with a Special Standing Committee on Midwifery. This recommendation culminated in the dismantling in 1983 of the Central Midwives Board and the General Nursing Council and the replacement of these bodies by the United Kingdom Central Council for Nurses, Midwives and Health Visitors (U.K.C.C.) and the four National Boards. This was the first time that nursing and midwifery had been jointly controlled by the same administrative structure, a structure largely dominated by nurses (Leavitt and Wall, 1984).

Midwifery teachers had been approved under the first Midwives Act of 1902 but were not required at that time to obtain education additional to that of midwifery. Following Doctor Campbell's recommendation in 1924, a teacher training programme was established by the College of Midwives in 1926. The Midwives Act of 1936 empowered the College to award a teacher's diploma to successful candidates. In 1972 the course was extended from day release to a full time, one year course in line with recommendations made in 1947.

A Report of the Sub Committee on Domiciliary Midwifery and Maternity Bed Needs was published in 1970 under the chairmanship of Sir John Peel, an obstetrician. The Report recommended the integration of maternity services and an obstetric qualification for general practitioners involved in maternity care. The most influential and far-reaching recommendation was for all confinements to take place in the hospital (Leavitt and Wall, 1984).

Lord Briggs headed a committee to review nursing and midwifery, whose report was published in 1972. The committee's frame of reference was to examine the role of nurses and midwives in the hospital and the community. While the committee stressed the differences between nurses and midwives they supported a previous recommendation for a joint regulatory body for the two professions. This recommendation gave rise to fears by midwives that they would be classified as nurses rather than practitioners in their own right (Donnison, 1977). These fears were realised during salary negotiations in 1988 when nurses and midwives were placed on a grading system which used the same type of evaluation of work responsibility for both professions as if they were equal in function.

The National Health Service was reorganised in 1974 by which time practically all midwives were employed by the Regional Health Authorities and working in hospitals or the community. Although midwifery remained under the control of a midwife at the local level it was often controlled at regional level by a nurse. By this time ninety per cent of all confinements took place in the hospital.

The creation of antenatal clinics led to a rapid increase in the utilisation of hospital beds. Concern expressed by the Central Midwives Board for improved clinical midwifery education led hospitals to seek more inpatients and outpatients for educational needs. The impact of this move was to decrease even further the number of home deliveries. This, plus the recommendations of the Peel Committee, led in 1979 to a fall in the number of home births from 107,099 in 1970 to 9,597. The hospital confinement rate of approximately 85% in 1970 increased to 96% by 1976 (Robinson, 1990).

In 1977 the Central Midwives Board raised the educational requirements for direct entrants into midwifery and requested an increase in the period of training for nurses and non-nurses and this finally occurred in 1981. Some of the functions of the Central Midwives Board were taken over by the U.K.C.C. in 1983 and some, such as the educational functions, were taken on by the National Boards also created in that year.

In 1981 an advanced diploma in midwifery was required prior to entry into the teacher's programme. It was deemed necessary because of the need for advanced knowledge of midwifery and related subjects. Designed primarily for teachers, clinicians and midwifery managers, the course lasts for 100 days (Bent, 1982).

The U.K.C.C became responsible in 1983 for establishing and improving the standards of training, professional conduct, rules of registration and maintenance of a single register among other duties. For the first time midwives were outnumbered by nurses instead of the doctors on boards which controlled their functioning. Although midwifery committees on the Central Council and the National Boards are responsible for advising their respective bodies on all matters related to midwifery education and practice, the Council and the Boards do not have to comply with the advice when formulating policies and rules. One example of this was the implementation of generic teachers in education at the English National Board despite the opposition from the midwifery committee. This implementation meant that midwifery education and approval could be and often was reviewed by nurses instead of midwives. Such a move suggests that many nurses perceive midwifery to be an extension of nursing.

In 1985 the rules for midwifery practice were revised and approved by the Minister of Health after taking into consideration the objections of the General Medical Council (R.C.M notes, 1985). These rules are contained in booklets provided to members of the midwifery profession. They govern training schools and specify teaching personnel, the number of programmes the midwifery school may teach and the yearly intake of students. While a core content for midwifery education is provided by the National Board, there is a great deal of flexibility in how the content is taught and who provides the information. This flexibility provides little direction or uniformity of standards among midwifery schools.

1.9 The Changes in Midwifery Care

Changes to the organisation of maternity care in the 1960's and 1970's led to many problems for midwives not least of which was the fragmentation of midwifery care. An added cause of erosion of the midwifery role was the increased hospital confinement rate and the early discharge of women to the community. A rise in obstetric interventions which started in the sixties increased more rapidly in the seventies and robbed many

midwives of the opportunity to use midwifery skills in labour and delivery. The advent of reproductive technology led to a further reduction in midwifery monitoring skills. There was an increased involvement by medical staff in ante-natal care and this led to the closure of many midwifery clinics with many midwives being used as 'chaperones' for the medical staff. (Robinson,1990).

Midwifery, following the medical model, became increasingly specialised during the late sixties. This resulted in a situation where midwives worked in only one aspect of maternity care, such as the labour wards or the antenatal clinics. Such specialisation resulted in fragmented care provided to women who were rarely cared for twice by the same midwife. Care was fragmented still further by the sharing of antenatal care between the hospitals and the community. Prior to the sixties when the confinement rate had been lower, hospitals had provided antenatal care only to those women booked for institutional confinement. With the increase in hospital confinements to approximately 96% this was no longer possible with the result that women now saw two sets of midwives and doctors, those in the community and those in the hospital (Robinson, 1990).

The fragmentation of care by midwives resulted in the fragmentation of clinical learning by students. Student education which had previously emphasised a client-based approach now became more task-oriented. Instead of providing continuing care for pregnant women students were placed in antenatal clinics in hospitals for several weeks and then the labour wards, the postpartum wards or the community. No longer did a student have the experience of providing care in the labour ward to a woman she had seen in the antenatal clinic or postpartum care to a woman whom she had delivered.

For midwives providing domiciliary care to women the changes in function have been just as dramatic as those faced by hospital midwives. The continuity of care they provided to women prior to the sixties has become fragmented because of the drastic reduction in home births. The reduction in time spent in the hospital for the postpartum period, often less than 48 hours, has increased disproportionately the amount of time spent on postpartum care. Many domiciliary midwives spend their day providing postpartum care with little or no time spent on antenatal care or on home births.

Additional problems faced by midwives and subsequently students were that changes in maternity care policies decreased the opportunity for all midwives to provide continuity of care and reduced their freedom to to make clinical judgements. One cause of these

problems was a recommendation by the Cranbrook Committee that doctors as well as midwives should be present at antenatal examinations and at deliveries. The Committee also recommended that doctors and not midwives be responsible for ensuring the coordination of adequate care. Additional problems have been caused through the increasing use of technology in maternity care which has led to an ever increasing number of interventions and thus even more involvement by doctors (Robinson, 1990).

It has been suggested that some midwives have embraced the 'medical model' of care because of their prior training as nurses (Donnison, 1988). This situation has led to a dichotomy within the midwifery profession of those who support such a model and those who seek a more client-focused and independent practice. The promotion of 'domino' deliveries (domiciliary in and out) whereby community midwives provide antenatal care in the community but deliver their clients in the hospital and discharge them home within 6 hours, has provided an increase in continuity of care to those community midwives interested in such care. However, this has so far only involved a small number of midwives.

It is obvious that the type of maternity care provided by midwives will have an effect on the clinical education of students because midwives provide the major part of clinical training. While there have been many changes made to the length of time required for midwifery training there is little evidence of an evaluation of the appropriateness of the content and style used by clinical midwives to teach midwifery skills. Little attention has been paid to the type of role model projected to students by midwives in the clinical environment. Given the present poor retention rate of midwives it would appear that this is an area in need of exploration.

Conclusion

Of recent years midwives have attempted to provide more continuity of care with the support of many consumer groups, such as AIMS (Association for Improvements in the Maternity Services). The Association of Radical Midwives (A.R.M), created in 1976, has attempted to overcome what they perceive to be the erosion of the midwife s role through the publication of articles, proposals for reform of maternity services and through the election of members to governing bodies such as the English National Board. Their support for continuity of care through such concepts as team midwifery has initiated a

response in midwives dissatisfied with their present fragmented role and the treatment of all pregnancies as abnormal (Robinson, 1990).

It is clear from this review that the role of the midwife has evolved over time to a functioning more dependent on the medical profession than is required by law. The suggestion that the requirement of nursing as a prerequisite for midwifery programmes in many schools has created a dependence in midwives on the 'medical model' has not been researched. What is clear is that for many nurses who became midwives there has been a confusion in their role.

Many midwifery students today are educated for a role that does not presently exist. They are educated by midwifery teachers to a philosophy which is not supported in clinical practice. Such a philosophy emphasises continuity of care and independent clinical judgements but there are few opportunities for students to learn this in practice. The lack of opportunity to practise clinical judgements and decision-making can result in a midwife who lacks confidence in her skills and relies on the medical profession for decisions. If the midwife then returns to the nursing profession there is no problem. If however, she stays in midwifery and becomes a preceptor to other students she may influence the students with her perception of midwifery or perpetuate in them the role in which she is functioning.

Secondary sources have been used to provide this history of midwifery. The rationale for this provision was the necessity of explaining the evolution of midwifery over time in order that the reader could understand the present context within which midwives are functioning. While it is important to understand the evolution this understanding does not have an explicit effect on the concepts identified or the developing theory. If this had been the case primary sources would have been used.

Little research has been devoted to how student midwives develop clinical judgement. Midwifery teachers provide the theory of midwifery but do not always work in the clinical area to integrate such theory with practice. As a result much of the emphasis on practice and the integration of theory with practice is left to the service staff who receive little training in teaching methods. This study has focused on how students develop clinical skills and decision-making and what influences affect this development. The next chapter will discuss how the the research approach for this study was selected and the research design chosen.

CHAPTER TWO

THE RESEARCH DESIGN

This chapter will describe how a decision was reached concerning the focus of this study and the use of a qualitative approach for gathering and analysing the data. Qualitative and quantitative methods will be discussed in terms of their attributes and drawbacks for this study. The aspiration to the use of a grounded theory approach will be described.

2.0 Background to the Problem

My initial reason in pursuing the subject of clinical education for student midwives was the proposed admission of midwifery as a health care profession in Canada. After I had trained and worked as a midwife in England I moved to Canada. I worked as a midwife and nurse in the Canadian Arctic where midwifery was not recognised as a legal occupation. After moving from the Arctic I was involved in the struggle to get midwifery legalised in Ontario. In 1986 the provincial government made a commitment to the establishment of midwifery and as an educator I became interested in how skills for midwifery practice would be acquired.

Canada is the only industrialised country not to have recognised midwives as non-medical practitioners. Prior to the last decade midwifery was considered a medical act and to practise midwifery without a medical license was considered to be illegal in law (Report on the Task Force on the Implementation of Midwifery, 1987). Health care in Canada is considered a provincial responsibility and therefore each province must make its own decisions on the type of health care it will offer. In the last few years there has been considerable consumer pressure brought to bear upon some provincial governments for midwifery to be legalised. In the province of Ontario this has culminated in a Midwifery Act which in November 1991 received full passage through the provincial legislature.

As a result of midwifery not being legalised in Ontario the present opportunity for training in midwifery is limited. Practitioners have obtained a variety of training ranging from a simple apprenticeship system obtainable in Ontario to a more formalised education available in countries such as the United Kingdom. The study of this situation would provide information on a dynamically diverse system constantly evolving to meet

new consumer, medical and political challenges. However, it would not provide the type of insight produced by a stable and single midwifery education system outside of Canada.

I determined that a study of a stable system such as that of midwifery in England would assist me in identifying some parameters for midwifery education and practice in Ontario. I wanted to update my own skills in midwifery in order to gain a current understanding of the context of my study. A mandatory requirement of midwives in Britain is that they have to complete a refresher course if they have not practised midwifery for five years or more (Handbook of Midwives Rules 1986). The length of the refresher course is determined by the number of years the midwife has not practised. I found I was required to undertake a 'refresher' course of nine weeks before I could regain entry into practice.

I had no clear concept of my study question at this time and so I decided that undertaking the 'refresher' course could also provide a useful base from which to make further explorations into the topic of midwifery. I had trained in midwifery when the course was in two parts, each six months long, and required me to obtain ten home births in order to qualify as a midwife. My first six months was spent in the hospital environment where I cared for pregnant women in the antenatal ward and then delivered them. During this time there were few obstetrical interventions and little technology. The last three months of the second half of my training were spent in the community where I provided continuity of care to women whom I had delivered in their home.

The refresher course would not only ensure my reentry into the profession but would also, I hoped, assist me in gaining access to a research environment. This hope was eventually realized and the course became the exploratory/ orientation phase for my field of inquiry. During my refresher course I became aware of a serious erosion of the role of the midwife. Because I did not work in other hospitals I was unable to verify whether the erosion was general or restricted to the hospital in which I worked. However, this erosion has been documented for midwives working elsewhere (Robinson et al, 1983). Midwives no longer appeared to be making decisions on aspects of antenatal care or during labour and delivery. This had not been the situation during my training period in 1967 and I became interested in ascertaining the factors behind this evolution.

Given my primary interest in student education, this restriction of the midwifery role and its possible effect on midwifery training became a more specific focus. Such a focus raised many questions. Was the way in which students were taught clinical skills responsible for this erosion or were they being taught in a specific way because of the lack of opportunities to function independently? Were they being taught to function within a reduced role? In an effort at objectivity I determined to study what factors appeared relevant in affecting a student's competence in midwifery skills. To strengthen the objectivity of the study I decided the students and midwives would define their perception of midwifery competency.

2.1 Identification of Methodology

It may be appropriate here to explain how I arrived at my decision to use qualitative measures. I previously used quantitative methods for my graduate work on nursing role conceptions, and I felt that to expand my knowledge of reseach methodology I wanted experience in the use of qualitative approaches. I had read about grounded theory and thought that its philosophy with regard to interactional analysis reflected my own.

There was no literature prior to 1988 on my topic in midwifery (the work of Davies, 1988 came out later in the year) and not a great deal of recent literature on experiential learning in nursing. This paucity of information provided additional support for my use of qualitative methods for the identification of concepts grounded in a contextual reality. The strategy I selected for my study was that of ethnography. Although ethnography has been around for a considerable length of time in anthropology and sociology but it is a relatively new method for nursing research. It focuses on culture and its system of rules, rights, roles, language, customs and established relationships (Wilson,1985). It appeared to me that describing the process of clinical learning within the cultural framework described, in its effect on the student's working life, would ensure that these aspects would be taken into account. After all this type of research attempts to tell the story of people's daily lives while describing the culture of which they are part (Burns and Grove, 1993).

A case study approach fitted easily with this ethnographic orientation, allowing focus on in-depth analysis of a subject for investigation under natural conditions, examining a small number of subjects with respect to a number of variables, including their everyday interaction. It can provide insight into little known phenomena and assist in the development of explanations of psycho-social and social-structural processes.

These strategies were identified in the order in which I have presented them. The initial decisions behind their choices have been given but further rationale for their use has been provided in the rest of the text under the appropriate headings. Before discussing the constraints and limitations of each method as they arose during my research I would like to present the evolution of my argument for the use of qualitative methods. I will then present the constraints and limitations of each method.

A perusal of the literature revealed a great deal of information on student nurse education but only one research reference on the education of student midwives (Davies, 1988). Robinson (1991) has surveyed the educational experiences and career intentions of newly qualified midwives while other researchers, such as Murphy-Black (1991) have studied post basic education for midwives and health visitors. A review of the literature in midwifery by Murphy-Black revealed that most of the emphasis was on midwifery policies, practices and the organisation of care.

While information on the education of student nurses was helpful, it related to a different situation from that encountered by student midwives. Student midwives are already, in the majority of cases, nurses and therefore have had a career in the health field before entering midwifery. Student nurses frequently enter the profession from secondary school and have had little experience of life in the health service and no previous socialisation to such a role.

The paucity of information concerning the clinical training and education of midwifery students led me to the conclusion that quantitative methods would not be helpful. A recognition that such a study required insights into student interactions suggested that qualitative measures would be the most appropriate. A review of research methodology indicated an ethnographic approach facilitating a rich description of clinical interactions and their analysis. I was particularly struck by the thoroughness of the process from intuition through to hypothesis formation in the work of Glaser & Strauss (1967).

2.1.1 Quantitative Research Methods

Quantitative methodology has been referred to as 'the scientific approach' reflecting the emphasis of many researchers that it is the most appropriate method for obtaining answers to 'scientific' questions. Increasingly, in the last fifty years researchers have become disenchanted with the limitation of such methods when studying many aspects of human

behaviour. Many researchers have begun to support the demand for field-oriented research (Yinger, 1967).

The relevance of strong versions of positivism from which most assumptions underlying quantitative methods arise is increasingly questioned when these are used to examine many aspects of social and interactional situations. In explaining events in a deductive fashion by appeal to universal laws, relationships between variables are hypothesized by these laws and are assumed to be present in all similar circumstances. As Hammersley and Atkinson (1983:4) state, it is the statistical version of this model where relationships have only a high probability of applying across all circumstances that has been adopted by social scientists. This adoption has encouraged preoccupation with sampling procedures.

A major concern with measurement oriented forms of positivism is the use of techniques to gain distance from the subject of inquiry. This distance is seen as necessary by users of quantitative methods to neutralize researcher bias. Methods used depend upon the research question and vary from complex experimental designs, using comparative measurements for experimental and control groups, to simpler designs using survey methods or questionnaires. The findings may be descriptive but quantifiable in nature or more statistically derived, such as that required for theory testing where quantitative techniques focus on empirical and objective analysis of discrete and preselected variables that have been derived as theoretical statements in order to determine their relationships (Leininger, 1985).

Quantitative studies lead to measureable, statistical and, in these terms, objective outcomes. Their value lies in the fact that they can be replicated and are often generalizeable to other populations. This standardisation of procedures allows others to replicate so that an 'assessment of the reliability of the findings can be made' (Hammersley and Atkinson, 1983 :5). Quantitative methods seek causes from the etic or world view and findings are based on the researcher's interpretation of hypothesised links between phenomena (Field & Morse, 1985).

Quantitative methods are less useful in field-oriented research because the standardisation of procedures and efforts to ensure objectivity through the use of scientifically tested tools, such as questionnaires, places distance between the researcher, the subject and the context. Burns and Grove (1993) questions the use of quantitative

methods in situations where research interaction is a factor. They argues that the emotional and social components of behaviour require methods which explore intention and interpersonal relationships.These cannot be discovered in depth by externally 'objective' indices.

2.1.2 Qualitative Research Methods

The emergence of 'naturalism' was a reaction against quantitative and survey research methods. While positivism stressed hypothesis-testing, naturalism portrayed research as a process of exploration. It required the researcher to collect and analyse data from the subject's view as opposed to collecting more objectively, distance-based data from a general view. 'Naturalism proposes that, as far as possible the social world should be studied in its *natural* state, undisturbed by the researcher' (Hammersley & Atkinson, 1983:6). Naturalism sets itself outside the natural world by offering alternative value-free interpretations of events. Both methods will have an effect on the collection of data.

Naturalism suggests that qualitative methods are the most appropriate for gathering data on the social world because they provide a richness and depth not achieved by quantitative methods. An argument for qualitative methods is that in field-oriented research the final concern is for the understanding and prediction of behaviour rather than the isolation of independent relationships between identified variables. It is suggested that by controlling the influence of other variables through analytic procedures we may remove the influences of other forces from a relationship but these forces are not removed in nature (Yinger,1967)

Naturalism suggests that in order to understand people's behaviour we must use an approach that gives us access to the meanings that guide behaviour, such as the context in which it occurs. This is important because behaviour never occurs in a contextual vacuum and people behave differently as a result of the demands of the context in which they are placed. To study behaviour within the context in which it is performed requires an approach that allows the researcher an intimate and sustained view of subjects. Qualitative research methods offer such opportunities. Qualitative methods, such as case study, phenomenology, grounded theory and ethnography provide the opportunity for a sustained and intimate view of subject response. Ethnography and case study approaches have been utilised for this study.

The use of qualitative methods requires the observation of a phenomenon in its natural setting. As Lofland (1971) points out, social events should be observed in their natural setting in order that the researcher remains sensitive to the conditions of the environment. Coles and Grant (1985) described qualitative research as a method of investigating problems, process, innovations and other events as they are encountered. It uses methods and techniques of observation, analysis and interpretation of attributes, patterns, characteristics and meanings of phenomena under study. It has been defined as a systematic, subjective approach used to describe life experiences and give them meaning (Leininger, 1985). Other researchers have applied a broad qualitative label to quantitative descriptive approaches which have been combined with qualitative methods such as ethnography (Knafl & Howard, 1984).

For the purposes of this study I will describe the defining characteristics most commonly associated with qualitative research. Qualitative studies are those in which concern with elements of the positivist paradigm leads to words and not figures being considered the elements of data, the approach to analysis is primarily inductive and theory development is the outcome of data analysis (Burns, 1989).

A major difficulty for qualitative researchers is the common assumption of quantitative researchers that the only valid basis of inference is that developed in relation to statistical analysis. The implication of 'no bias' is that the sample selected accurately reflects the characteristics of the parent population. A representative sample is required because inferences are to be made about the parent population from the characteristics identified in the sample. Inference from the sample is about the concommitant variation of two characteristics (Clyde-Mitchell, 1983).

The goal of the qualitative researcher is to identify patterns of commonalities by inference from specific ideas to more generalized ideas This process should result in the identification of concepts and potential relationships (Field & Morse, 1985). Features present in the data can be related to a wider population because the analysis is situation-specific. It does not require the sample to be representative in terms of population but does require it to be representative in terms of characteristics and knowledge required for the study. The characteristics and the theory are embedded in the data and are therefore valid. Logical inference is epistemologically quite independent of statistical inference and therefore the critique of sample is not valid for logical inference (Clyde-Mitchell, 1983).

Both quantitative and qualitative researchers are rightly concerned with the need to cope with the effects of the researcher on the data. For one, the solution is the standardization of research procedures and the 'elimination' of the researcher. For the other, the direct experience of the social world by the researcher is required, given the recognition that the chosen methodology cannot eliminate researcher effect on the data because of the nature of his/her being. Hammersley & Atkinson (1983) argue that because we cannot avoid affecting the social world we study we should use the knowledge productively. Instead of treating subject reactivity as a source of bias it should be exploited by using the information in other situations. How people respond to the researcher can be used in the examination of their response to other situations. This suggestion was found to be useful in this study,for example when two subjects were encountered who had given permission to be studied but evaded the researcher whenever possible.This type of behaviour was observed to be present in other situations when the subjects felt threatened.

I have described the opposing arguments of quantitative and qualitative researchers for the support of their approaches to research inquiry. That is not to say that I support the notion that one approach is better than another because of its underlying philosophy. What is important is the understanding that the approach selected is the appropriate one to answer the question. Quantitative methods are most useful when variables have been operationally identified and their relationship can be tested within the framework of one or more hypotheses. Qualitative studies are necessary when there are no clearly identified variables or when one wishes to pursue a topic, such as human interactions, in depth. Quantitative studies build upon and test the knowledge and theory produced by qualitative studies. Qualitative studies may build upon quantitative results by providing in depth information on why one variable may affect another and produce more than one outcome.

2.2 Symbolic Interactionism in Qualitative Research

Symbolic interactionism is a perspective on society and people that emphasizes the need to conduct research in natural settings. It focuses on the way people define their reality and construct their actions over time. Symbolic interactionist philosophy underpins most qualitative research (Wilson, 1985).

Symbolic interactionists study behaviours on two levels, the interactional level and the symbolic. Studies in this framework must include observations of behaviour in specific situations and the expressed meaning of such behaviour for the individual. In other words, the full range of behaviour is sought. Analysis of interaction includes participant's self-definitions and shared meaning. To be understood human behaviour must be examined in interaction (Chenitz & Swanson, 1986).

Symbolic interactionists conceptualise behaviour in complex situations, such as unresolved or emerging social problems and new ideologies. They reject the stimulus-response model of human behaviour which has been built into the methodological arguments of positivism. Interactionists believe people interpret stimuli and these interpretations are constantly under revision as events unfold and shape their actions (Hammersley & Atkinson, 1983). The usefulness of the interactionist perspective lies in the fact that the research situation is dynamic and observers/interviewers are perceived as actors who produce and elicit behaviour along with other actors (informants or subjects).

Denzin (1978) suggested that the study of symbolic interaction rests on three assumptions. The first is that social reality is a social production and as a result, interacting individuals produce and refine their own definitions of situations. The second assumption is that humans are presumed capable of shaping and guiding their own and other's behaviour. The last assumption is that in the course of identifying their own views or adapting to the views and behaviours of others, humans interact with one another. This philosophy underlies many of the inductive theory generation modes.

2.3 Qualitative Methods: Grounded Theory

Atwood (1977) suggests there are many inductive theory generation modes. Phenomenology is one and ethnographic methodology yielding taxonomies another. A third is grounded theory The major use for grounded theory has been in preliminary, exploratory and descriptive studies. The methodology entails beginning with a conceptual perspective about a problem to be studied. This perspective guides open-ended data collection, concurrent coding and analysis of categories. Data gathering then becomes more structured in order to identify properties of categories, hypothesis formulation and refinement of theory elements. The product is newly generated but not empirically tested theory (Glaser & Strauss, 1967). It is these properties of grounded

theory which make it uniquely suitable for this kind of study where the knowledge base is limited and the variables have yet to be identified.

The generation of grounded theory is inductively arrived at from data which are systematically obtained and analysed. Grounded theory provides a set of interrelated propositions designed to explain, describe and predict a social process. The key theoretical elements are categories, properties of categories and hypotheses deduced from the data to produce theory and then tested empirically. A category is a theoretical element at the construct or concept level. A property is a finite unit which is a conceptual aspect or part of the category.

I had hoped to use a grounded theory approach in this study because of its potential for generating theory and because it appeared to me to provide a certain logic and structure to the conduct of a qualitative study. In addition I felt that its philosophy of social and symbolic interactionism provided an appropriate basis from which to study the meaning of the clinical reality of the student midwife. I considered that a grounded theory approach would enable me to manage large amounts of qualtitative data in a logical fashion and would provide direction for both the collection and analysis of such data, deduced from the data to produce theory and then tested empirically.

Concurrent data collection and analysis is a strength of grounded theory in that the analysis of emerging themes dictates a more focused approach to subsequent data collection. The analysis of the data as it is collected allows for more focus on the themes and the flexibility of following such themes to their conclusion (Corbin and Strauss, 1990). Subsequent data sampling can be used to saturate identified categories and to test developing theory through hypothesis. The researcher may then leave the field when no new themes have emerged from the analysis and collection.

Unfortunately I was unable to use the grounded theory approach in the purist sense because of time constraints in the field. I gathered observational data on a daily basis and spent time, when possible, on transcribing my notes. During transcription a superficial content analysis was undertaken and general ideas noted from the data. As these ideas began to build I would follow them up in the field in terms of focusing my observations and my interviews on them. Although such themes were the early harbingers of emerging categories I am unable to say that these categories were delimited and saturated prior to leaving the field.

The vast majority of my analysis attempting to approximate the constant comparative method of analysis requisite to grounded theory practice was done in the following six months to a year after I had left the field. This is due to the fact that this type of analysis is extremely time consuming and I would have had to spend up to two years in the field in order to saturate categories. Collecting the data, subjecting it to content and latent analysis, and the constant comparative method, and then going back into the field to collect more data on these ideas, would have delayed the end of my study still further.

Corbin and Strauss (1990) suggest that saturating categories is not necessarily a requirement for the identification of theoretical propositions using the grounded theory approach. Saturation can be achieved during data analysis after the researcher has left the field if the collection has been sufficiently focused. In every other aspect the method for the grounded theory approach in my study was adhered to especially with regard to ensuring verification of the results. Theoretical sampling is an approach devised by Glaser and Strauss (1967) for sampling other data after the researcher has collected, coded, and analysed data already in hand. The emergent concepts from the analysed data direct the researcher to other sources of data which will strengthen or add to the results. An example of this would be to sample data which reflect specific themes from the observations of subjects and search for the same themes in data obtained from interviews. The researcher will sample data from more than one source in an attempt to verify the value of a variable and its distribution. The researcher also seeks out informants who can provide the same type of information as that obtained from the subjects (Atwood, 1984), or challenge the themes being developed. In this study I sought out other midwives and midwifery teachers. More detail on the analysis of data is provided in chapter three.

Accurate description and verification of identified categories are also crucial for the validity of the results. The researcher has to ensure that appropriate rigor is applied to the collection of data, analysis and theory generation. Replication is considered to be the best means of validating facts. Facts can be confirmed with comparative evidence either internally, externally or both. Evidence was collected from comparative groups and used to check on whether the initial evidence was correct. The task of the researcher is to discover the relative truth in a situation, discover people's beliefs and identify congruence or lack of it between belief and action with participant observation. The use of informal/formal interviews with observation increases validity since it assures that observational perceptions are checked through active questioning (Chenitz & Swanson,

1986). It was not possible in this study to seek out students on other study sites and so midwifery teachers and midwives, especially those newly qualified, were interviewed for corroboration of themes.

Data for various categories are usually collected from a single group but data from a given group may be collected for one category. The analyst is continually dealing with a multiplicity of groups I could not identify initially how many groups would be sampled as this depended upon their availability and the stages of their training. In the end five groups of students were studied in depth, with midwives and teachers used for additional sources of information.

As in fieldwork, additional comparison groups can be selected from library material after the analytic framework is developed. The literature was reviewed initially to provide ideas on education of health professionals. After themes began to emerge from the data the literature was reviewed again in terms of themes and then comparison groups developed. This provided concurrent validity of the data. An example of this is when the communication category began to emerge from the data in this study a comparison group was found in Kirkham's work with midwives in the labour ward (Kirkham, 1989). Although Kirkham was studying midwifery interactions with labouring women her identification and description of inappropriate communication patterns corresponded to those emerging from my data.This addition of comparison groups from the literature provides an increased confidence in the credibility of the framework. Comparison groups provide simultaneous maximization or minimization of both differences and similaries of data that bear on the categories being studied.

2.4 Qualitative Methods: An Ethnographic Approach

Ethnography has become the label used for a generalized approach toward conceptualizing understanding human behaviour from an emic or subjective view. Ethnography is the systematic collection, description and analysis of data for a theory of cultural behaviour. It is broadly similar to symbolic interactionism in its method of studying social processes to yield theories of cultural behaviour. Ethnographic research studies a way of life as it is experienced by a group of people who share the same culture, language, dress and customs. Multiple methods of data collection may be used to provide detailed accounts of events, situations and circumstances that are usually difficult to discover at all or in the desired depth by other research methods. Ethnographers ask questions, such as 'in what

ways do members of the midwifery profession actively construct their social world?' (Fawcett & Downs, 1986).

An ethnographic design was used because it was felt that student midwives constitute a cultural group in that they share common experiences in their daily working lives. Through interactions with their learning environment and each other they learn symbols, meanings and language which form their professional world. This common language and use of symbols forms the boundaries of their world and is often meaningless to others who do not wholly share in the professional socialisation and practices. To understand the meaning of such experiences to them a researcher must take a cultural approach in seeking out the reality of their world from their perspective.

A value of the ethnographic method is that the researcher is less likely to maintain misconceptions in the face of extended contact with people. The ethnographer has constant opportunity to 'check out' his or her understanding of the phenomena under study. The description of perspective and activities within a defined setting allows one to develop theory in a way which provides evidence of the plausibility of different lines of analysis (Hammersley & Atkinson, 1983: 24).

Ethnography requires the same systematic processes of observation, description, documentation and analysis as are required for symbolic interactionist study. A further value of ethnography is its flexibility. Because it does not entail entensive prefield work design, the strategy and direction of the research can be changed in line with data requirements for theory construction. Indeed it is committed to fundamental reflexivity as part of an adequate framework for social research. Reconstructing our understanding in line with the implications of reflexivity characterises the process of ethnographic work and marks it off from traditional positivism.

The main methods of ethnographic data collection are observation and interview. Participant observation is the method par excellence of symbolic interactionists. It requires the selection of small samples and relatively few informants. It is usually accompanied by the collection of documents and unstructured interviewing which are combined in the completion of descriptive analysis. The subjects designate the units of reality. The analyst formulates the units into definitions and adopts research methods to implement the lines of action and assess the activity for its ability to develop, test or modify social theory (Denzin, 1978).

2.4 1 Sampling

Selecting cases for investigation is not the only form of sampling in social research. Sampling can also be done within cases. Hammersley & Atkinson (1983) suggest three major dimensions along which sampling within cases occurs: time, people and context. Because of the impossibility of twenty-four hour research, some degree of time sampling must be attempted. This study identified particular reference periods to study, such as the first hour of the antenatal period when new mothers are seen and the changeover of staff on the postnatal wards. Sampling can also be done along demographic lines if such characteristics as gender, age, education and occupation are not standardised as they were in this study.

Sampling for variations in context is important because different contexts elicit different behaviours from the same people. Delivering a baby requires a different set of behavioural responses from a student to those required of an antenatal examination. Contexts must be identified in terms of which people in the setting act, recognizing that these are social constructions and not physical locations. Variations among people, occasions, time and contexts may or may not be significant for emerging theory (Hammersley & Atkinson, 1983).

Denzin (1978) suggest theoretical triangulation for ethnographers not wishing to limit themselves to a single theory as a framework for data analysis. This method is a way of approaching data from multiple perspectives and with multiple hypotheses. Data source triangulation is a method which involves the comparison of inferences from one set of data, such as observation with those from data of another source, such as interviews. All of these methods provide validity and reliability checks upon the data and give added depth to descriptions of social processes.

2.5. Case Study

In selecting among the various research strategies the type of research question asked is of prime importance. Case study is a preferred method when examining events within a real-life situation and when relevant behaviours cannot be manipulated. Its unique strength is its ability to encopass a variety of data. The focus may be a single individual or a group of people engaged in a sequence of activities over a restricted or extended period of time

Case studies present a method of organizing social data in order to preserve the unitary character of the social object being studied (Yin, 1984).

Case study analysis of a social situation reveals the way in which general principles of social organization manifest themselves in some specified way. Case studies are generalizeable to theoretical propositions and not to populations. The case study does not represent a sample and the researcher's goal is to expand and generalize theory by analytic generalization (Clyde-Mitchell, 1983).

Justification of the selection of a case for study is in terms of its explanatory power rather than its typicality. Any set of events deemed to reflect the abstract characteristics required by the observer for analysis may be used. The analyst's purpose is to demonstrate how general explanatory principles manifest themselves over the course of time (Clyde-Mitchell, 1983).

Eckstein (1970) distinguishes between five categories of case study. The first category he refers to as configurative-idiographic. The material is largely descriptive and reflects the circumstances surrounding the events in a way which may provide insights into the relationship amongst component elements. This type does not easily lead to direct theoretical interpretations and is therefore ideal for descriptive study such as this. The second category is the disciplined-configuration. It has patterns of elements which the observer does not treat as unique. Instead the observer seeks to interpret the patterns in terms of general theoretical postulates. Category three is chosen specifically to develop theory and is called heuristic. Plausibility probes are category four and are used to test interpretive frameworks established by other case studies or procedures. Category five is used to enable analysts to support or reject a theoretical proposition. This category is called crucial case study.

As with other qualitative methodology approaches the problem with case material in theoretical analysis is the extent to which the analyst is justified in generalizing from a single instance or event. The object of the analysis is not culture but social processes which may be abstracted from the events analysed. Inferences on case study material is based on the validity of the analysis and not on the representativeness of events. Inference about the logical relationship between two characteristics is based upon the plausibility of the connection. Dependent upon the theoretical explanation advanced for the linkage, the inference can be statistical or a scientific or causal one. Statistical inference where

conclusions are drawn about the existence of two or more characteristics in some wider population from a sample of that population are not invoked in case studies (Clyde-Mitchell, 1983).

Case studies are a reliable and respectable procedure for social analysis (Yin, 1984). The inferential process is based exclusively on the theoretical linkages among features of the case study material. Extrapolation depends upon the validity of the theoretical analysis and not the representativeness of the sample. Case studies are uniquely designed to deal with multiple sources of data produced by the ethnographic method of research study.

2.6 Validity and Reliability

In quantitative research, reliability refers to the degree of consistency with which an instrument measures the attribute it is designed to measure. Assessing reliability in quantitative terms can be done in several ways but the one used most commonly is the test for internal consistency. The most common way to assess for internal consistency of a tool is the split half technique which uses statistical methods, such as Cronbach's alpha or the Kuder-Richardson formula 20. Another method used to assess reliability is the equivalence approach which is used when different observers are using an instrument to measure the same phenomenon at the same time or when two presumably parallel instruments are administered to subjects at the same time. The reliabilty measures for different observers is to use the interrater reliability approach but in both situations the aim is to determine the reliability of the instruments in yielding measures of the same traits in the same subjects (Polit & Hungler, 1991).

It is clear from the discussion above that these types of measures are not too useful in qualitative research where the researcher is the instrument. Interrater reliability is not a useful consideration for observational methods except in ways alluded to in 2.4. While there does not seem to be a wide margin of error in quantitative terms it is possible that it could eliminate a whole category or some of its properties in qualitative terms. In addition, without structure to the observations individuals with different life histories will have different perceptions on what is being observed.

One method to assess the reliability of the researcher as an instrument is the triangulation of methods for data collection. In this study such triangulation was used. Observations were made and transcribed and followed where possible and as frequently as possible by

informal interviews with the subject of the observation. This approach was used to identify that what was observed was congruent with what the subject perceived as happening. The observations were transcribed and analysed and questions identified to use in formal interviews with the subjects to gain their perception of events and themes arising from those events. Documents were used where possible to verify observations in such areas as labour ward, antenatal clinics and the wards. If observations were perceived to be related to education, then curriculum documents, documents on clinical rotations of students and midwifery teacher's perceptions were used to verify reliability.

The question of validity in qualitative research refers to how good is the answer provided by the research. The characteristic of validity in qualitative or quantitative studies is the notion of error. The greater the error the less valid or truthful are the results. "Validity" in quantitative research refers to the degree to which an instrument measures what it is supposed to be measuring' (Polit & Hungler, 1991: 657). Again, one cannot measure degrees of measurement when the researcher is the instrument. Instead one has to determine what approaches will strengthen the results and increase the rigor of the study.

2.6.1 Strengthening Qualitative Results

One way in which results may be strengthened is to ensure that the sample used is truly representative when theoretical sampling is used. In theory-generating studies which use qualitative methods, non-probability or convenience sampling, frequently called theoretical sampling, is appropriate. It is also important for the strength of the results to take note of any problems which reflect a bias of the researcher towards specific subjects. In this situation the researcher has favourite subjects that she observes and questions more frequently. This is not a problem if the researcher recognises it and does not allow the analysis to be biased in favour of these subjects.

During analysis the researcher can reduce bias and check the content validity of his/her developing categories by using a colleague with a similar background to analyse some of the transcripts. The colleague is provided with unmarked transcripts and asked to analyse the data for emergent categories. The results are then compared with those obtained by the researcher. This was done for this study but the results were not quite as expected for several reasons. Some categories were the same but the majority were different and this was assumed to be because the researcher and the colleague had very different backgrounds. The researcher was a nurse and a midwife but the colleague was a nurse. Both had similar levels of education but they were in different fields. The colleague had

worked only in England while the researcher had worked in Australia and Canada as well as England and Wales. As a result of this variance of backgrounds we often focused on different parts of the data and produced different categories.

The exercise above was useful in making me more aware of my biases and limitations. Unfortunately, I had no colleagues at that time who were midwives with the same academic level as myself to use assessment of construct validity. As a result I determined to use the midwives themselves and my subjects to verify the content validity of my categories. This was achieved in three ways. The first way was through questions added to the formal interviews to identify that my line of reasoning was appropriate. Miles and Huberman (1984) suggest that this is not a valid exercise because the research instrument is still the same, the researcher. However, it could be argued that the subject's response will provide different data because the question posed is focused whereas the observations made are made on behaviour occurring within a context. I have to admit that it is not a perfect method but it does provide a way of reducing bias.

Another method I used was to present the categories and themes as they emerged from my research to midwives attending research sessions as part of continuing education. Results of these discussions were incorporated in a second set of informal questions used in interviews of subjects, midwives and tutors. A third method was to present the emergent categories at a national midwifery conference and at smaller midwifery conferences as well as to colleagues.

A final step made to verify concepts was the search for negative cases. To achieve this I actively searched for disconfirmation of what I actually believed to be true. I went back to the data to seek out evidence to disconfirm the conclusions I had provisionally arrived at. An example of this was in respect of the themes of inappropriate communication. Having identified them I went back to the data to seek out themes where communication had been used appropriately for teaching students. Seeking out 'appropriate communication' clarified the ongoing theme of 'poor communication' and helped to define its parameters.

One method which was not used but could have ensured greater reliability and validity of the data would have been to use an expert qualitative researcher to validate the categories. In this situation the expert would have been provided with transcripts of the unmarked data and a list of categories with their properties. Congruence would have been assessed with how frequently the expert was able to identify the same categories in the data as

myself. This was what I had attempted to do earlier with my nursing colleague but I had failed to realise that I could not expect him to identify categories before I had identified them myself. It is only in retrospect that I realised that this assessment required the structure and properties of the categories before assessing their validity with another reasearcher.

2.7 Limitations and Constraints of Research Methods

Some of the limitations have already been identified in the text. Performing content analysis on the transcribed data before returning to the field to collect more data increased the time interval for this study. Using constant comparative latent analysis increased further the time required for the analytic procedure. I was unable to do this for all of my categories with the result that I was unable to identify all of the properties of the later categories of socialisation and the learning process. The core category of communication, which was a dimension of the problem of learning, was saturated and its properties clearly identified and this did provide some strength to the emerging theory. It was also quite frustrating to find some themes emerging from the analysis after I had left the field and to know that I would be unable to collect more data on them.

Constraints related to the ethnographic method involved the use of myself as a participant observer. It was very easy to 'go native' and ally myself with the students and I found that I had to take time out in the early data collection periods in order to regain some objectivity over my observations. Part of the problem of 'going native' was the anger I experienced as a result of the treatment given to students by a few of the midwives. Attempting to control my anger led to periods of fatigue which again required an absence from the field to regain control and energy. Objectivity over my emotions and observations became a skill which evolved over the time spent in the field and became a valued outcome of my research. At this stage it is difficult to know how much bias has influenced my interpretation of the data although I did attempt to reduce this by obtaining the student's perception of the events.

Summary

The focus of this study was developed sequentially from a general need to obtain more information to develop midwifery services in Canada, to an interest in the clinical education of students. This focus was refined as a result of my nine week attendance on a midwifery 'refresher' course where I observed the erosion of the midwife's role. In

attempting to ascertain the cause of the erosion in my own mind I reflected on the role of education as a factor in such erosion. Was the erosion the result of a lack of confidence in midwives with regard to their skills and if so, what was the cause? As a result of these thoughts the question became clear. What factors affected students' clinical competency and confidence in their midwifery skills?

To study a topic on which little depth of information is available requires the use of qualitative research methods rather than quantitative methods to identify variables and hypotheses which may then be tested by quantitative methods. Ethnography was chosen because it is uniquely geared to the study of cultures and encompasses the strengths of symbolic interactionism, a theory of behaviour in a natural setting. Such a study utilises observation and structured and unstructured interviews to obtain data which can be inductively analysed to produce the elements of theory.

The use of concurrent collection and analysis of data, an aspect of grounded theory, allows for more flexibility in the investigation of interactions and their meanings. Analysis of such data is best served by using constant comparative analysis which combines latent content analysis with theoretical sampling methods. The usefulness of the grounded theory analysis lies in the description of processes occuring in social situations and in the formulation of hypotheses (Fawcett & Downs, 1986). A major limitation in this study was the fact that I had to leave the field before my categories had been saturated. The case study approach was considered as part of the methodology because it is uniquely geared to handling qualitative data and can encompass ethnography.

The design of the study was ethnographic and utilised the principles of grounded theory in a case study design. More detail on the design will be discussed in the next chapter along with a description of the site and negotiations for access. The research process is described along with the researcher's experience of carrying out the fieldwork.

CHAPTER THREE

THE RESEARCH PROCESS

In the previous chapter, different research paradigms and their associated methods were analysed for their relevance to this study. The rationale for adopting a case study ethnographic approach with grounded theory analysis was described. This chapter will provide more specific detail on the design selected and a description of the negotiations for access to a case study site. A brief historical description of the study site is also provided for its relevance to present day functioning of the hospital. The methods employed for data collection will be discussed along with their analysis and a consideration of the extent to which the original research objectives were met. The final section comprises an account of the researcher's personal experience of carrying out the fieldwork.

3.0 Design of the Study and Implications of the Design

The choice of framework within which to undertake the research process does not necessarily predetermine the research design although it does make certain methods more appropriate than others. In this instance using observation, semi-structured and unstructured interviews were considered to be more appropriate for gathering data than the use of quantitative methods, such as questionaires. Selection of an appropriate design is also influenced by other factors, such as the type of information required, practicalities of fieldwork and constraints of time and money. At this point it would be useful to identify the overall aims of the project.

3.1 Unit of Investigation

I determined that the unit of investigation would be an urban maternity hospital which taught student midwives as part of its service. The hospital which I selected was also chosen for other reasons The first of these was that the hospital was a high risk referral centre and therefore had a heavy emphasis on the use of technology in childbirth. One of the areas I wanted to explore was the effect of technology on student learning because this would be the type of environment to which student midwives in Canada would be exposed. Because of this emphasis on technology it would be difficult to find a comparable hospital environment in the immediate environment for study which would

allow the findings to be more generalizable. A second reason was that the financial and time constraints of unfunded research restricted my research activities to one case study site.

3.2 Observations and Interviews

Information on learning opportunities and the way in which mature learners, such as nurses, take on the student role influenced my decision to use observation and interview for collecting data. Learners acquire knowledge from the clinical field at different rates and often use different methods for its acquisition. The process of learning in clinical situations is complex because it is influenced by many variables. These include programme and clinical objectives, a wide range of practice settings, diverse abilities of learners, skills, experience and motivation of instructors and the interpersonal and group dynamics operating in the clinical field (Vollman, 1989).

With all these variables at play observation of the student in all clinical environments would provide a more comprehensive and dynamic picture of factors affecting learning than could be provided by a survey method. Predesigned and structured instruments can blind the researcher to the dynamics of the site. If the most important phenomenon is not represented by the instrument it can be overlooked or misrepresented (Miles & Hubermann, 1984 :42). Interviews were used to validate the observer's perception of activities in the clinical field as well as to validate themes arising from the data. Student midwives were the subject of observations and formal and informal interviews. Interviews were also obtained with midwives, midwifery teachers and managers.

Observation as a method for studying learning is not ideal as it represents a unidimensional focus on activities ocurring in the study site. It captures a moment in time which does not necessarily mean that moment will be replicated at a later date. However, such a moment can be expanded by questioning the subject for perceptions of the event and how it relates to prior and subsequent events. This provides as much of a comprehensive picture as is possible with a single observer. In the interests of expediency this researcher worked on the premise that the major proportion of student learning of skills would take place when there was an activity to be performed. As a result, observations were geared only to activities and not to the quiet periods in the clinical area.

A decision was made not to include observations in the classroom. I wanted to maximise the clinical focus, and constraints of time prevented me from being able to observe in depth in the classroom as well as in the clinical environment. Important considerations for the emphasis on clinical learning is that it may be restricted in its replication, sometimes to a single emergency to which the student must react, or it may be restricted by the ethics of practising on human beings. Such restrictions emphasise the importance of efficient and competent clinical learning. The midwifery curriculum is set nationally by the English National Board and must meet the requirements of the European Council Midwifery Directives. While the presentation and adaptation of the curriculum is the responsiblity of the individual midwifery schools the general curriculum is common to all students in England and Wales.

3.2.1 Format and Method of Observing Students

Students were observed in all clinical areas but there was more access to some areas than others. Clinical areas with the easiest access were the ante and postnatal wards, the antenatal clinics and the delivery suite. Of these areas the antenatal ward was accessed the least because students were not placed there until their senior year. Negotiating access to the community was difficult initially as the manager expressed reservations about allowing me access to their clients. One problem identified was that the client would be exposed to a larger number of people than usual. With the presence of the midwife, student and myself it was a lot to expect of some clients particularly those with very small homes. After negotiations with individual midwives, limited access was obtained.

The Special Care Baby Unit was another area difficult to access mainly because of the size of the premises and the sickness of the babies. Although many attempts were made to access this area the frequency of very sick babies requiring additional medical personnel reduced the amount of space available for observations. Although I was not refused entry during these periods I elected to remove myself in order to ensure the cooperation of the staff for future access. As a result, only a limited number of observations were made in this environment.

3.2.2 Format and Method of Recording Interviews.

Interview schedules were unstructured at first and followed observations. Interviews gained a little more structure with the progress of the data collection and identification of themes in the data. Sufficient structure was used in later informal interviews to ensure

clarification and validation of themes and observer's perceptions. Interviews remained open enough to provide opportunity to change direction and follow up on new themes.

Having realised during my pilot project the difficulty of keeping copious notes I determined to tape record all interviews. I felt that not only would it reduce the possibility of missing verbal cues but also it would be less likely to inhibit the flow of the interview as a result of pausing to take notes. This did create a problem in two situations when subjects refused to be taped but granted an interview.

3.3 Sample

Sampling involves not only decisions concerning which people to observe and interview but also about settings, events and social processes (Miles & Huberman, 1984: 37). Because qualitative research is a largely investigative process one makes gradual sense of the studied phenomenon by contrasting, comparing, cataloguing and classifying the object under study. These are sampling activities to identify the variability and commonalities of a social universe. They are conducted progressively and iteratively by the researcher.

Participant observation as a method to study interactions requires the selection of small samples of informants. In order to sample across time as suggested by Hammersley and Atkinson (1983) I chose five groups of student midwives representing five intakes of students over the eighteen month programme. From each intake I selected five students for a total of twenty five students. I observed one group from the beginning of their training, one group who had almost completed their programme and three groups between these extremes. The project then took the form of a cross-sectional study of learning opportunities in the clinical environment in respect to student midwives in different phases of their training experience.

In sampling across events in the clinical environment I chose as my parameters such activities as, a booking visit, the admission of mother and infant to the postnatal ward and a woman admitted to the delivery suite. I sampled for variation in events because different contexts like different environments usually elicit different behaviours.

3.3.1 Observations.

The focus of the project was on how students learn and what factors in the environment inhibit or assist that learning. Behavioural skills were chosen for observation as these skills

were anticipated to demonstrate that learning had occurred. When that learning occurred is beyond the scope of this study other than to ascertain that the subjects had a perception of having learned or refined a skill during the interaction. This perception was validated and clarified through informal interviews which took place as soon as possible after an observational event.

A question that began to emerge during the observations was whether or not the student had the theoretical knowledge to apply to the specific clinical area in order to gain the skill. One could assume that because all of the students were exposed to a common curriculum then a demonstrated lack of knowledge must be specific to that student. However, one could also argue that as each group had a different tutor this would also have an effect on students' knowledge. This theme was identified as an issue which may have an influence on student learning and although it was not a focus of the study it was a dimension that was included in the later interviews.

3.3.2 Interviews

These were used initially to validate the observer's perceptions of the social interactions taking place in the setting. Later they were also used to validate themes arising out of the data. Initial questions were in the format of "Why did you perform that procedure? Did you feel comfortable doing that procedure?". Later questions related to specific themes and these can be seen in Appendix B.

As the interviews became more structured the questions became more focused in areas, such as preparation for skills, supervision during skills demonstration, feedback from the midwife and conceptual frameworks for the skill. Documentary evidence to substantiate the themes was also sought from the curriculum.

3.4 Study Site.

3.4.1 Selection Criteria

Five selection criteria were considered in compiling a list of hospitals suitable for selection as a case study site. These applied to a site which could:

1) Provide me with both a refresher course and subsequent access for research purposes.
2) Provide high technology obstetrical care. This was required in order to answer the question of whether technology had an effect on student's skills learning.

3) Provide an environment in which there was a visible and possibly dominant medical presence. This was expected to provide a context for investigating the effect of a dominant medical presence on students' skills competency.

4) Be central to a large city because of financial contraints.

5) Train registered nurses for midwifery.

A list of hospitals was compiled but only one met the first criterion. Another was willing to provide the refresher course but for a longer period than I required. This same site exhibited no interest in my research and the head of midwifery education implied that she was willing to take me despite this problem. Several other sites either did not respond to my enquiry or else stated that they could not take me unless I was willing to work for them at the end of the course.

The site finally selected appeared very flexible in its educational policies and interested in my research topic. The education staff were less structured in their approach than those from the other hospital but indicated a willingness to meet my needs with regard to the refresher course and my research.

3.4.2 History of Site.

The case study site was a large urban maternity hospital with a long tradition of training midwives and postgraduate medical staff. The hospital began life as an apartment accommodating 25 women. Since then it has moved several times before arriving at its present location where it is, like many hospitals in Britain, under a renewed threat of closure. The hospital was opened because of the concern of one doctor for the fact " that in this great and opulent city a hospital for taking care of exposed and deserted young children and poor women labouring with child has been long neglected" (Reference withheld to protect the site).

Teaching was from the first a major part of the workload of the attending physicians. However, it is not clear from historical accounts whether the initial recipients of the teaching were medical students or pupil midwives. One could assume that because education for women was not in fashion at that time the recipients were medical students or other doctors.

From the beginning the hospital encouraged confinements from diverse parts of the world and gave priority to the wives of servicemen. Its reputation was such that between 1752

and 1768 it received women for confinement from 57 parishes in the city In addition 496 women came from different parts of the kingdom and from France, Virginia, the Carribean and East Indian colonies and settlements. This diversity became a problem after the establishment of the National Health Service (N.H.S)

The hospital was from the first, like many hospitals, supported by charitable donations. This did not change until it was taken over by the National Health Service. The donations caused many problems for the administration budget holders because of fluctuations in the amounts. However, it became very fashionable to support the hospital through payment for the admission of 'worthy' women.

In 1762 the hospital became one of the first to offer outpatient as well as inpatient services. Services were provided for confinement in the client's home by the hospital. By 1819 outpatient figures had surpassed those of inpatients. A major reason for this was that many women became aware that to deliver at home provided a better chance of survival. This outpatient service provided the basis for the present community midwifery services which are hospital based.

Pueperal fever became a serious problem in all maternity hospitals but especially so on this site. In her 'Introductory Notes on Lying-in Institutions' published in 1871, Florence Nightingale was critical of the design of the hospital because of poor ventilation and drainage. The first recorded evidences of the presence of pupil midwives was in response to the problem of puerperal fever at that time. While unsure of the cause of the epidemic it was determined to restrict the movements of the pupils between infected and non-infected patients. There was no such rule documented for the doctors.

In 1873 the office of resident medical officer (R.M.O.) was created. Under the old system Matron had called in doctors only when obstetrical problems arose. With the new appointment of the R.M.O. matron was relieved of her midwifery practice but retained responsibility for the midwives. This was the beginning of the erosion of the midwives' control over normal births on this site. A resident midwife was appointed but this was soon abandoned as it was felt that she would become contaminated by mixing with nurses and conveying infection to the wards. Again, this did not appear to present a problem for the R.M.O. By 1877 the mortality rate due to puerperal fever was down but rose again in 1879. The matron was promptly blamed by the medical staff and fired after 20 years service.

By 1875 there was documented evidence of the training of five pupil midwives and fifty-two monthly nurses. By 1885 the numbers had risen to nineteen pupils and one hundred and forty monthly nurses. Very few medical students were in attendance at that time because midwifery was not required on the medical examination.

During this time pupil midwives were given a three month course for twenty six shillings and five pence. Lectures were given by the R.M.O. and other physicians attending the patients. The pupils were examined by the physicians and if found satisfactory they were given a diploma. The hospital was called a midwifery training school from 1874 and its pupil midwives appeared to have a lot of support from the medical staff. By 1899 the hospital had achieved a good reputation for the training of midwives and it began to receive more applications for training than could be accepted. This is still the case today. One of the reasons for the good reputation is that hospital pupil midwives were well prepared for examinations set by the Central Midwives Board. Hospital pupils achieved a pass rate of 92-94% compared to the national average of 80-83%.

The accepted format at this time was for midwives to care for all patients considered to be progressing normally. Doctors were involved only with patients who were experiencing problems or abnormalities. Approximately five per cent of the patients required forceps. This is in stark contrast to the present obstetrical and midwifery care (See Appendix C).

The Central Midwives Board, composed mainly of physicians, helped to consolidate medical dominance of pregnancy by requiring the appointment of an R.M.O to antenatal clinics. This appointment was made for the R.M.O to attend all cases reported as abnormal by midwives. Over time the role of the medical staff has evolved to include the examination of all women whether they have problems or not.

With the advent of anaesthesia for labour came the appointment of more medical staff. First a resident anaethetist was appointed closely followed by the appointment of a paediatrician and assistant paediatrician. Such medical appointments reduced the role of the midwife in terms of pain control in labour and the care of the newborn. In 1931 the opening of a research laboratory led to the appointment of a consultant bacteriologist to deal with the ever present puerperal fever.

By 1912 the advantages of attracting midwives who had had a nursing training was recognised and they were given a one month reduction in the course from 5 to 4 months of training. During the same period complaints were received from medical students that their training was being ignored in favour of the needs of pupil midwives. There is no documentation on the action taken at this time but the administration was known to favour the midwives as their subsequent actions show.

During the 1930's the midwifery training school flourished with an annual average of one hundred and thirty pupils, the majority of whom were nurses. At the same time the hospital was coping with an annual average of one hundred and forty medical students. To add to these problems the Ministry of Health declared it could not be a teaching hospital because it had no gynaecological patients. The hospital negotiated for a liason with another hospital which had gynaecological patients but no maternity care. This liason finally came to fruition resulting in the move of staff and patients to the site hospital after structural changes had been made. The changes and the move were partially accomplished during the fieldwork period and created not a little stress for the staff and students on site.

In 1946 the number of maternity admissions exeeded 3,000 for the first time and there were 1,371 deliveries at home. There began to be an increased emphasis on hospital confinements with the result that home confinements fell to 335 in 1966. The continuing emphasis on hospital confinements has ensured that the number today does not exceed a yearly figure of 40. There are midwifery plans to increase this number.

An innovation occurred as a result of general practitioners' complaints about the lack of cooperation they were receiving from the hospital staff. Although they were referring their patients to the hospital they felt they received little feedback on their condition. As a result of negotiations between obstetricians and G.P's an arrangement of shared care was organised. This involved the patient keeping a special card which gave the details of her medical and obstetrical history and care during pregnancy. Wherever she was seen, whether in the hospital or in the G.P's office, the results were documented. This became referred to as the 'Co-op' card. Unfortunately this card was indirectly responsible for a further reduction in the role of the midwife. Midwives had been examining normal pregnancies referred to the hospital by the G.P. This fact showed up on the Co-op card. As a result the G.P's demanded that if they were going to refer patients to the hospital those patients should be seen by the medical staff. This was insisted upon despite the fact that the junior doctors did not have the equivalent training and experience of the midwife.

3 4.3 Description of Study Site

The hospital is on the edge of an inner city. Due to its reputation for research and obstetrical excellence its clientele are referred from other health authorities. It has no specific geographical boundaries and referrals are accepted from clients as well as their doctors and other obstetricians. Clients with high risk pregnancies and limited local resources may come from a distance of 80 miles outside the city. The medical staff consisted of 8 consultant obstetricians with 8 senior house officers and 4 Registrars. In addition there were anaethetists, paediatricians, haematologists and a medical physician with special research interests in pregnancy.

The hospital had the following features:

1) An antenatal clinic on the ground floor consisted of 12 examining rooms and two waiting areas.

2) There were one hundred and fifty inpatient beds with an occupancy rate of between 54-68%. It provided both inpatient and outpatient maternity and gynaecological services. At the time of the fieldwork inpatient gynaecological services were not offered on this site.

   i) There were three wards, one of 33 antenatal beds and two with 65 combined postnatal beds.

   ii) One isolation ward on the third floor encompassed 4 rooms. In the same area was a delivery room used by the community midwives for 'domino' deliveries. Down the hall from the isolation ward was the fetal medicine unit which contained three admission beds.

   iii) The delivery suite on the top or fourth floor had 20 beds for labouring women. One ward consisted of 6 beds for those in early labour and the remainder were single rooms. One room was used principally for caesarean sections.There was a two bed unit used for the recovery of patients who had undergone surgery.

   iv) The neonatal special baby care unit was on the second floor. It had 5 intensive care cots and 15 high dependency care cots. This ratio changed according to neonatal requirements.

   v) There was a special suite on the second floor with 7 beds for private maternity patients.

It is easy to see from the geographical organisation of the hospital environment that it promoted the fragmentation of learning experiences from the students' point of view.

Additional statistics for the study site 1988

Average length of stay	4-5 days
New bookings	3,000 per year.
Deliveries	4,195 + 6 babies born before arrival
Home births	11
Community antenatal visits	1,029
Community postnatal visits	2,426

Administrative Structure of Case Study Site

Unit General Manager
(non-health person)

Area Chief Nurse

Midwifery Services Manager

Senior Midwife Teacher | Patient Services Manager | Manager Support Staff

Midwifery teachers | Managers

A.N.C | Labour Ward | P/N Ward & A/N Ward

3.4.4 Staffing Patterns

3.4.4.1 Hospital Staff

Day Duty Roster — Minimum of 2 midwives and one sister per ward plus 2 students, 1 nursing auxillary and 1 ward clerk.

Evenings & Night Duty Roster — Minimum of 2 midwives, 1 student midwife and 1 auxillary.

Midwifery staff were allocated to specific clinical areas for a period of six to twelve months but it could be longer. The philosophy behind this was that it would enable midwives to gain expertise in one area. Unfortunately, while expertise had been gained midwives felt very alienated from other areas of maternity care. This method of allocation of midwives had also led to fragmentation in midwifery care.

The Special Care Baby Unit was the one area in the hospital which employed nurses. They were registered general nurses and some had a certificate in neonatal intensive care The hospital also provided a six month course in neonatal intensive care for nurses and midwives who applied from any health authority. These courses ran continuously and placed a heavy emphasis on clinical placements with the result that they are often inundated with students. While there were two clinical teachers for these courses the majority of the clinical teaching was the responsibility of the individual nurses in the unit. With the addition of midwifery students to this area the nurses could be overburdened with teaching responsibilities.

3.4.4.2 Community Staff

Community midwives were appointed to their post after a minimum of 2 years experience following completion of their training. Although geographically based they were attached to general practitioner obstetricians' clinics in their area for the provision of antenatal and postnatal care. There were over 300 clinics serviced by the community midwives who had their headquarters on this site. There were 18 community midwives at the initiation of this project and they were divided into 3 teams of 6, each with a team leader. This was felt to encourage continuity of care because team members relieved each other on their days off. The teams offered a domino scheme. This involved seeing the client in the community antenatal clinics, meeting her at the hospital when she was in labour, delivering her and discharging her after four hours if all went well. If not, she was admitted to the wards where the hospital midwives discharged her at the appropriate time. Home births were not actively encouraged by many of the community midwives because they were discouraged by hospital policies, the views of general practitioners and their own time constraints. However, if a woman requested a home birth the midwife was bound by law to attend. Unfortunately this was a fact of which very few women were aware.

3 4.5 Midwifery School Staff

The midwifery teaching staff consisted of one senior midwife teacher, six midwifery teachers and two clinical teachers.The senior midwife teacher had many years of midwifery educational experience and was close to retirement. The six midwifery teachers ranged in age from thirty four to forty eight years. Additional information was not gathered on them or the clinical teachers because they were not the focus of the research.

Midwifery teachers were required to have at least two years of midwifery experience before they could apply for the advanced midwifery diploma (A.D.M). This diploma was required before midwifery teachers could enter the teacher training programme, the Post Graduate Certificate in Education of the Adult (P.G.C.E.A). The A.D.M and the P.G.C.E.A were required by midwives before they could become registered with the UKCC as midwifery teachers.

3.4.5.1 Programmes.

The midwifery school provided a mulitiplicity of educational programmes:

1) The 18 month midwifery training programme was the primary focus of the department. The school was funded for 3 intakes of 16 student midwives or 48 per year. The average was 12 students to a set. During the fieldwork period 4 sets were accepted because of the integration of midwifery education at the study site with that of another two hospitals. The educational level of the students was high with many achieving the standard of university entrance. The last student set to be studied by the researcher was one from the new integrated educational system. This meant that some of the students were clinically placed at another site. I chose only those students designated for the case study site even though others volunteered.

2) A refresher course for midwives who had been away from clinical practice for a period of time. Refresher programmes for midwives are compulsory under the Midwives Act (1979). There were two types of programmes; one for midwives who were working in the area of midwifery and required a one week update of theory every 5 years, and one for those who had been away from clnical practice for some years. The latter type of programme required both extended theory and clinical practice and was provided at the case study site. This was the programme

I undertook prior to my fieldwork. The school has now ceased offering this type of programme but continues to offer the one week refresher programme.

3) A family planning programme was offered on a regular basis. This was open to both midwives and nurses from all health authorities.

4) A six week clinical period was provided for general nursing students who required maternity experience as part of their curriculum.

5) A twelve week educational and clinical experience was provided for students who were preparing to become health visitors. This was a compulsory requirement at the time of the study but is no longer required.

6) E.N.B. 405 was the six month neonatal intensive care course for nurses or midwives described earlier. There were two courses per year.

7) Inservice education for all midwifery and nursing staff was provided and was based on staff needs. There were 6 days allowed per midwife, per annum.

Some of the information provided here is already outdated but was current at the time of the fieldwork.

3.4.6 Midwifery Curriculum

In the midwifery education department students were taught using the modular system. The curriculum was presented in 8 modules over an 18 month period and this method was approved by the E.N.B. Forty medical specialist lectures were provided as per E.N.B. requirement. This requirement has since been changed to 40 specialist lectures which no longer have to be provided by medical staff. This enabled midwives with specialist knowledge to provide this theoretical component. The modules are as follows:

Module	**Content**	**From weeks**
Module I	Introduction to midwifery	1-7
Module II	Community practice	8-13
Module III	Antenatal clinics	16-27
	Postnatal care and care of the neonate	28-30
Module IV	Special care baby unit	34-46
Module V	Abnormal labour and delivery	49-52
Module VI	Community practice	53-59
Module VII	Antenatal & postnatal care	60-67
Module VIII	Free allocation	68-74

3 4.7 Clinical Allocations.

Clinical placements varied because all students could not be accommodated in the same area at the same time. One of the problems identified in the past had been that students had been placed in clinical areas for which they had received no theoretical preparation. The education department was aware of this problem and had tried different methods but not all had been successful because of the constraints of the clinical area. The integrated group of students, the last group to be observed by me in the field, were the first to be exposed to these methods. A discussion of this will be provided later in the chapter on analysis of data.

A typical student placement is as follows:

Week	Placement
1	Study Block
2	Antenatal Clinics
3-4	Labour Ward
5-7	Postnatal Ward
8-13	Community
14-15	Holiday
16	Parentcraft
17-21	Antenatal Wards
22-27	Central Delivery Suite
28-30	Postnatal Care
31-32	Holiday
33	Study Block
33-36	Postnatal Care
37-39	Central Delivery Suite
40-46	Speacial Care Baby Unit
47-48	Holiday
49-52	Central Delivery Suite
53-59	Community
60-63	Postnatal Care
64-67	Antenatal Ward
68-70	Holiday
71-72	Special Allocation*
73	Study Block
75	State Exam (Written)
77	State Exam (Oral)

* The student's choice of clinical placement.

3.4.8 Student Residence

The majority of student midwives in the sample lived in the residence alongside the hospital. It consisted of 3 floors of which the second and third were living quarters for

staff. The first floor was used for offices and a fertility clinic. There was no lift to connect the floors and students living in had to drag their belongings up several flights of stairs.

At the beginning of the fieldwork there was no security in the residence. Anyone had access to any of the floors from the street below up until 2100 hours when the ground floor door was locked. Access was then obtained using an identification card. Following the attempted rape of a midwife in her room the doors were locked at the entrances to all floors.

The rooms for residents are small and those on one side faced a busy road and could be very noisy. Rooms alongside the hospital lacked privacy as patients and staff from the upper floors could see into the rooms. There were two kitchens, eight bathrooms and four showers for approximately 40 residents on each floor. The bathrooms were old-fashioned with tiled floors. They were in a state of disrepair and often had no light. The showers were tiny cubicles with temperamental faucets which rarely combined hot and cold water to the appropriate degree of heat.

The reason many students gave for living in was that they could not afford to live out. Most students professed a dislike for the residence and complained about the lack of amenities such as a well equipped kitchen. A large number of the rooms were also used by support staff who are mainly Filippino in origin.

3 4 9 Financial Arrangements.

Students lived in the residence because their rent was subsidised by the health authority. Without this type of arrangements many students said they would not have applied to the programme because they could not have afforded to live in the area. Students received salaries according to the Whitley Council pay guidelines. The salary was that of a beginning staff nurse regardless of the level achieved in the N.H.S. prior to their student status. This was often a bone of contention because they felt they had lost money by entering the midwifery programme. The debate became even more heated when the new grading system for pay awards was introduced.

The new grading system for pay awards was introduced towards the end of the fieldwork and caused much acrimony when midwives found they had been placed on the same scale as nurses. There were over 100 appeals of the grading structure in this hospital and one heard of many similar appeals elswhere. Some staff left for hospitals where the grading

structure was more favourable for midwives. Still others returned to nursing where they had perceived the career structure to be more favourable.

3.5 Negotiations for Access to Study Site.

3.5.1 External Negotiations

Time was spent in October 1987 with the English National Board (E.N.B.) midwifery educators discussing the research project. Information was verified, such as the common curriculum for all midwifery schools, the new structure of the legislative bodies and the position of midwifery within that structure. I was also interested in which midwifery schools provided refresher courses for my own needs. The feasiblity of the research project was discussed and the general receptivity that midwifery schools might have toward such a project. The E.N.B expressed interest in the project as a means of identifying some variables which could be used to guide education departments in the clinical training of midwives.

Four weeks later I obtained from the E.N.B a list of midwifery schools which provided refresher courses. The E.N.B had examined my documents and determined that because I had been out of the country for 18 years I would require the full 12 weeks of a refresher course. This was the amount of time reserved for midwives who had been out of midwifery completely for more than 8 years. I had been teaching maternity care in Canada for some years and I felt this was unfair. After further discussion they decided that the hospital providing the course could shorten the time required if they were satisfied with my progress. I eventually completed my refresher course in eight weeks.

The E.N.B. midwifery education officer had identified some midwifery schools which she felt would be receptive to a research project. The case study site was on the list. However, it was not felt to be a 'good place' because of its high-medical profile. I explained that this was exactly the type of place I was searching for because of my study questions.

After identifying midwifery schools in the specific urban area in which I was interested I found I had a total of nine. Of these nine, four did not reply to my enquiries, one placed me on a waiting list for several months hence and two said they could not accept me unless I was willing to work for them afterwards. Hospital A offered me an interview in November 1987 and Hospital B, which was to become the case study site, rang my home

at the end of December 1987 to offer me a place on the refresher course commencing January 1988

I attended the interview at Hospital A and was offered a place on the course. The course was 13 weeks, 3 weeks longer than required by the E.N B. and I attempted to negotiate a reduction to no avail. Hospital A did not take the individual background of applicants into account and there was no adaptation to individual needs. They expressed little interest in my research. I accepted the place they offered because I felt, not having heard from hospital B at this stage, that I was unlikely to get another place within my time constraints.

When I was finally contacted by a midwifery teacher from Hospital B, three weeks before the start of the refresher course, I arranged to visit them. I found the education department to be less structured in comparison to that of Hospital A and with no documented plan for the course. Hospital A had already sent me a list of other participants, the theory to be covered and the clinical areas for placement. However, I found Hospital B to be very interested in my research and very receptive to reducing my programme if I proved myself satisfactory at an earlier date. Upon consideration of all the factors involved, I withdrew from the course at Hospital A and accepted a place on the course at Hospital B.

My rationale for completing a refresher course covered three main factors. I had not practised midwifery in Britain for 20 years and had not worked in the British health scene for 18 years. During that time the health scene had changed considerably partly as a result of various working parties (Briggs, 1972; Peel, 1970) and partly as a result of changing governments and their differing commitments to the N.H.S. Health Authorities had evolved from Local to Regional to Area health authorities during the period that I had been absent. I also felt a need to update myself with regard to government policies and their effect on the health care system and hospitals in particular. One of my advisors pointed out that the refresher course would not only give me an update on midwifery practice but also could be used as an exploratory phase for my study.

During the refresher course I negotiated for subsequent access to the students and different clinical areas on the site.

3.5.2 Internal Negotiations

3.5.2.1 Access to Students

I met with the senior midwife teacher and explained the project. I asked her whether there was an Ethical Board which would review my proposal. I was told that the ethical review board was medical only and related to research performed on patients. She felt that as my research focused on students that she could give me permission to proceed. She then arranged for me to meet with the midwifery teachers and I explained the project. When I stated that I hoped they would feel they could participate the senior midwife teacher informed them that it was expected of them. While no one objected to this statement I was left feeling as if coercion had been used. However, they all willingly agreed to my speaking to their students on their various study days. One laughingly remarked, "you can have mine all day if you want".

I discussed the project with each set of students and ensured that each was aware that they did not have to participate if they did not wish to and that it would not affect their standing in the school in any way. I then left them with a form which they were to sign if they were interested in participating. At the end of the study day the teachers would hand the paper to me.

When talking to the students and the teachers I emphasised four main points:

1) The research would not focus on how good or bad the student's skills were but on who taught them in the clinical area and what methods were used.
2) The data would be treated with the strictest confidence and would be destroyed at the end of the study.
3) All participants would be identified by letters in order that anonymity could be preserved. The form on which the students gave their permission restated that the information would be confidential and that the students could withdraw from the study at any time.
4) All people were at liberty to choose whether or not to participate. If a decision was made to participate the subject could still withdraw at any time.

Approximately seventy per cent of the students in Sets A, B, C, and E signed the paper. There were only five students in Set D and all of them signed. Only one midwife refused to be interviewed when asked and all of the midwifery teachers agreed to participate.

Questions asked most frequently by the students were as follows:

Q1. "Are you actually going to follow us around the ward and watch what we do?"

A1. "Yes, but I will not be observing you for how well you perform in the clinical area but for who is teaching you and how."

Q2. "Will we be able to see what you have written about us?"

A2. "No, but I will share with you the ideas coming from the data at the end."

Q3. "Will we be able to find out what comes out of this if we have left by then?"

A3. "Yes, I will send you an abstract of the findings if you write and ask me."

Q4. "Do you think this study will make any difference to the way they are teaching us now?"

A4. "I hope so. It will be presented to everyone including the tutors and will make recommendations. The school is very interested in the study and hopefully they will act on the recommendations."

Surprisingly, few students seemed concerned about such factors as confidentiality and anonymity. The majority seemed positive about the study, expressing the belief that it would help other students even if it was too late to help themselves. Some expressed some anxiety about being 'watched'.This was given by some as the reason for their refusal to take part in the study. One student was pleased that a 'midwife was doing research as it was usually only done by the doctors'.

3.5.2.2 Access to Staff

Following the successful negotiations with the school of midwifery I arranged for an interview with the Patient Services Manager for access to staff and sites. During the interview there was a further reiteration of the view by the manager that I did not need to go through the medical ethical review board as it was a 'midwifery matter'. Again, I received encouragement for the project and it was arranged that I attend the next sisters' meeting to explain the project.

When I arrived at the meeting I found a very formal situation with the Patient Services Manager at the head of the table flanked by her senior midwifery managers. The ward sisters were placed at the lower end of the table.The manager opened the meeting by introducing me and explaining my role but referred to me as 'staff nurse'. The group were told that they would be 'involved' in the project. I attempted to defuse this by saying that they had a choice but was left feeling that I made little impression. When I had finished a description of the project I asked for questions. There was no response. Eventually a staff midwife I had been working with asked me a question related to obtaining information at the end of the study and I responded. Again, there was silence after which the manager thanked me implying that it was time for me to leave.

3.6 Ethical Considerations

In retrospect, I realised that although my study was low-risk with regard to the patients there was considerable interaction between them and the students to which I had access. Ethically it would have been a good move to apply to the board not only as a review of my ethical procedures but also to notify the medical committee that I was carrying out a research project. This notification of medical staff was done on an ad hoc basis when they were present during my observations. However as Archbold (1982:157) states, calculating ethical risk is difficult in a qualitative study because as it progresses it modifies the process and necessitates a change in the estimated significance of the study. As data analysis begins with the data collection, the analysis can lead the researcher down paths not envisioned at the inception of the study.

However, I realise now that I failed to recognise the extent to which the patients would become part of the study. I believed I had protected them sufficiently by explaining my position each time and asking for their permission to stay. Now I realise that they may, because of my identification of myself as a research midwife, have felt that they had little choice but to acquiesce. My desire to 'get on' and do my research may have blocked my mind to ethical considerations that I would normally have included in my negotiations.

3.7 Exploratory Phase

The exploratory phase began with the commencement of the refresher course which lasted approximately eight weeks. A week of theory was provided to give an update on midwifery. This was extremely basic because we were placed with nurses who were

obtaining a maternity course prior to entering the course for health visitors. Most of the refresher midwives found it boring. After the initial week we were placed in clinical areas with one day a week for study in the classroom. Weeks 2-4 were spent in the antenatal clinics, 5-7 in the central delivery suite and week 8 on the community. All of these experiences were shared with student midwives.

Initially I found little time to make surreptious notes because of the amount of re-education I had to undergo. No one in the clinical area or my refresher group was aware of my research activities as a participant observer and so my notes were scribbled during 'toilet breaks', coffee breaks or after meals. Some semblance of order in my note-taking was attempted in some of my free time but this was not consistent due to my fatigue. This was especially a problem during my labour ward experience and therefore I have less documented experience of this area.

3.7.1 Themes

3.7.1.1 Lack of welcome.

Several themes came out of my refresher course experience which in some senses felt like something of a pilot project and became part of the focus of the fieldwork observations. The themes were identified from my analysis of data collected on my interactions with other refresher midwives, midwifery staff and student midwives. The initial and overwhelming observation was the lack of welcome accorded to the refresher midwives as a group in the clinical area. We received the impression that we were just another problem which had to coped with. The educational staff had made us feel very welcome and part of the staff. This was in direct contrast to the situation on most clinical sites. The antenatal clinics and the central delivery suite were the worst for demonstration of an unwelcoming attitude.

3.7.1.2 Conflict

In the clinics there appeared to be a great deal of tension between staff and some conflict over the midwife's role in relation to the medical staff in the clinics. Some midwives, often the newly qualified ones, felt that they should not be chaperoning doctors who often repeated and disagreed with their findings. Many of the doctors had far less experience than the majority of midwives working there. These midwives felt their role was to provide midwifery care for their own group of clients and the doctors should be catered to by the nursing auxillary. One midwife stated that she had no job satisfaction and was only working there because the day shifts and weekends off suited her lifestyle. She went on to

state "I worked in the labour ward for six months but the pace was so hectic that I had to get out".

A minority of midwives were quite happy to leave the decision-making to the medical staff and became very angry when anyone suggested a more autonomous midwifery practice, stating that they were the ones that had to work there and pick up the pieces after the others had left. A couple of midwives said they would like to try to practise a more independent role but that in a confrontation with the doctors they felt they would get no support from their sister for their position. As a result they felt it was not worthwhile attempting to make the changes.

The clinic staff also complained that it was either 'feast or famine' with regard to 'bodies' in the clinic. Some days there were 3 refresher midwives and 4 students and other days there was no one extra to provide service to the clients. The study days of the students and the refresher midwives did appear to coincide. However, I was unclear what the problem was because the clinic staff seemed to view us all as 'bodies' to care for clients and not people who required teaching and supervision.

3.7.1.3 Reduction in Status

The refresher midwives, along with students, were treated in a different way by the nursing auxillary who appeared to have some power in the clinic as a result of her long term of office. When it was time for the afternoon teabreak, the 'refreshers' and the students were expected to pay 10p for their tea (2p more than it cost in the cafeteria). We were unable to leave the clinics to go to the cafeteria because of the large numbers of clients still waiting to be seen so we had little choice. However, the midwives and the doctors paid nothing and were also offered cakes. I was unable to ascertain what the students thought of this discrepancy but the 'refreshers' were vociferous in their condemnation of it to each other, though they did not mention it to the staff.

The students I observed interacted very little with the rest of the staff unless they had a clinical question to ask. They rarely spoke and went quietly about their work. My perception was that they were going to extreme pains to avoid being noticed. Unfortunately, I was unable to validate this perception because it became apparent to me only after I had studied my transcribed notes after I had left the clinic.

3.7.1.4 Supervision

Some of the students appeared to be supervised while others did not. This was strange as they were all from the same set and therefore at the same stage of training. When I asked one of the midwives about the variation in supervision she told me that each midwife determined how much supervision she would give the student under her care. Some received total supervision while others were left on their own and told to contact the midwife if they had any problems.

Although our time in the clinic was short I found we rarely had the same supervising midwives for both morning and afternoon. This caused considerable confusion because the midwife we worked with in the morning would have a different style to the one who supervised us in the afternoon. We would then find ourselves in trouble with the second midwife because of something we had done which had been a requirement for the first midwife. Educational objectives were undermined by a couple of midwives who would make statements, such as "I know you are taught that way in the school but we don't do things that way here".

3.7.1.5 Inappropriate Responses

Some of the midwives, although very pleasant with the women, often missed their distress cues with statements such as, "Is he still alive?" accompanied by a laugh, or "I dreamt last night that the baby had died." Some cues were more subtle but even the obvious ones such as these were treated in a joking fashion rather than followed up. One woman had lost her husband in a car accident the previous year and her father four months ago. The midwife, who appeared to be a sympathetic and caring individual, treated the information in a very business-like fashion with no attempt at a therapeutic communication.

After leaving the clinics we moved onto the labour ward. Prior to going there we were regaled with many stories about the working conditions and our potential treatment by the staff. I found I was unable to sleep the night before my first shift because of my anxiety and arrived on duty feeling very tired.

There was no welcome on the labour ward and everyone appeared to be staring at the new faces. The orientation to the area was brief, lasting approximately two hours, after which we were expected to be able to find most things and know what we were doing. No one expressed any interest in our previous work experience and it appeared to be counted as neglible.

After the orientation, two of us were 'thrown in' to observe an emergency caesarean section but ended up taking part. The scrub midwife appeared to be in a bad mood, constantly making demands and inappropriate comments about our lack of expertise in a loud voice. An elective section followed this and it appeared that both I and the other 'refresher' midwife were now considered part of the staff and expected to do our part. The labour ward sister assured us that she would keep an eye on us in case we needed help but we never saw her again.

As time progressed things did improve and we began to find we could sleep the night before a shift on the labour ward. The next area of anxiety and concern was over the three supervised deliveries required by the E.N.B of 'refresher' midwives. First, we had to observe three normal births. I found that we were often rushed in at the last minute for the observation and therefore were unable to see the preparation of the patient and the room prior to the delivery. Some people may not consider this to be a problem but in a hierarchical system such as the one on this study site, where you put your swabs or instruments was of paramount importance. Some midwives appeared to get quite upset if an instrument was two inches to the left of where it should be placed.

I observed one of my fellow 'refreshers', F, when she was about to perform her first delivery. Her hands were shaking badly and she did not speak to the client either to give her instructions or words of encouragement. When I spoke to the client, to encourage her, I was told by the sister to keep quiet. F told me afterwards that she already knew how that sister would behave and that was why she had kept quiet.

I found that each day I was on the labour ward I scanned the staff duty roster to see who was most likely to supervise my first delivery. However, when my first delivery came I had few problems with the supervising midwife but the client was extremely uncooperative with the delivery which did not help my confidence. During my coffee break a student asked me what I was going to do when I finished my course. I explained about my research and she seemed very interested. When I asked her how she thought she learnt her clinical skills, she laughed and said, "trial and error". A second student that was present agreed, and said, "It's not often that you're supervised, especially up here"

I eventually managed to obtain three normal deliveries, though I had been very concerned because prior to my last day on labour ward I had obtained only two. I had no desire to

return to labour ward to get my third and even stayed on the ward for an extra six hours in the hope of obtaining a delivery, whereupon having spent 12 hours with a client, she required forceps to help her deliver. On my very last day I managed to get two deliveries and I left the place with a sigh of relief. My poor experiences with one or two midwives had given me negative feelings about the area.

Many of the midwives had been very pleasant and had attempted to teach both us and the students. However, they appeared to have no understanding of our different needs. Regardless of the stage of the student's training and our experience, terminology and teaching content for each group was the same.

After leaving the labour ward, I was sent out with the community midwife. On arrival in the community office I was met by a pleasant midwife who had been on call the previous night. She offered me a cup of coffee and told me the staff would be in soon. Staff came and went but no one seemed to be responsible for me I found afterwards that my own midwife, Sister X had been there for about ten minutes but had not looked for me. After introductions she told me she had some details to sort out before we could leave. I watched her interactions with other midwives and they did not appear too friendly except for those who were members of her team.

After this inauspicious beginning we got along well once we found we both had Canadian connections. She had worked in Canada some years previously and was delighted to be brought up to date with the country. The geographic area covered by this midwife was very interesting encompassing some very wealthy patients who had received private health care to those in small cramped flats. However, she had no really poor people, such as those in bed and breakfast lodgings.

The most frightening aspect of community midwifery for me was coping with the traffic. X did not appear worried about this although she said it drastically cut down the number of visits that could be made in one day. Sister X was a ferocious driver taking great pleasure in cutting in front of large expensive cars. She seemed to take great exception to them being allowed on the road and felt it was her duty to put them in their place. Needless to say I spent the entire week hanging onto the doorstrap and praying for deliverance.

Sister X had an interesting approach with her patients, combining modern midwifery with homeopathic and herbal remedies. Her patients seemed to be very attached to her. She

was very patient and I never saw her angry. Unfortunately, it appeared that her mixture of treatment methods along with her personality ensured that she rarely had students for supervision. This was mainly because sister X's manager did not feel she would be a good role model for students. This was unfortunate because she was interested in teaching and appeared open to new ideas and interested in testing them out.

3.7.2 Summary of Themes

In summary, the themes that arose from this refresher course/exploratory phase were associated with the socialisation process. The lack of welcome and of supervision, the treatment of previous experiences as non-contributory to the re-education process and the reduction of 'refresher' midwives to problem 'bodies' to be utilised in the work area as required, were very obvious socialisation issues. The anxiety surrounding new experiences with no attempt by the staff at alleviation was another theme to be investigated in the study project. The needs of service appeared to be of primary importance with the need for education taking a distinctly second place.

While all of these themes were investigated they did not exclude others which emerged during data collection. They did however provide an initial focus in observing and collecting data from the field in an efficient and productive manner. There is always the danger that a researcher becomes focussed on orienting or initial themes to the exclusion of others. I did not find this to be a problem. Indeed I felt that the opposite occured. With a theme on which to focus my observations I was able to perceive what interactions produced the behaviour and how the subsequent theme had evolved.

3.8 Fieldwork Planning

Because of this initial experience, there was little need for me to orient myself to the fieldwork area. The fieldwork began at the end of April in 1988 immediately after I had completed my refresher course. Decisions had aready been made with regard to the fieldwork sites to be covered. These included the antenatal clinics and wards, the central delivery suite and the postnatal wards. I felt that it was not necessary to include the community where it was obvious that one-to one-supervision was a given. I felt one could assume that teaching would occur under those conditions. However, I later realised that not only was this an assumption based on my own experiences but also I was narrowing the focus of the research. Unfortunately, this insight occurred only later in the fieldwork

period. Given this and access problems, I was unable to observe many of the sample when they were very junior students in this milieu.

A similar decision was made about the special care baby unit where access was also a problem but for different reasons. The unit was very crowded and often housed more incubators and cribs than it had initially been designed to hold. This left little space for the nurses and parents, without additional bodies crowding in. With the admission of very sick babies this paucity of space became more encroached upon by medical staff and inhibited the movements of staff caring for other babies. Although I made several trips to the unit to observe students, these trips almost always appeared to coincide with the admission of sick infants. The experience happened once in the students' senior period and for only one six week block. As a result of these factors only a small number of observations were made in this unit.

Information on the following was obtained from documents in order to assist with the planning of the fieldwork.

1) Curriculum content for the midwifery training programme.
2) The sequence of the clinical allocations for each student in the sample.
3) The duty rotation of each student.

While all three pieces of data were of great importance for planning, the second and third were the most important for efficiency of time use. Knowing where the student was and which shift she worked enabled me to reduce the amount of time spent searching for her. Sufficient time was wasted by me when searching for students who had been sent to other wards, were off sick or changed their off-duty. Fortunately these instances were not too common.

Documents, such as birth statistics, medical interventions and surgical outcomes, were examined to obtain an idea of the practices to which the students had been exposed. Policy manuals present on each unit to provide staff with guidance for midwifery practice were also examined. Demographic data were retrieved from student personnel files after the subjects had consented. Files were not accessed that belonged to students not in the study group.

Although I deliberately attempted not to associate myself with either midwifery 'management' or 'education', I was initially perceived to be part of the education staff. I believe this was because of the nature of the study and the method of access to the students rather than because I was seen as an 'educator'. Subsequently, when students spoke to me disparagingly of the 'school' I believe their perception of me as part of that system had changed.

The fact that I was a midwife was occasionally a problem when the students were interacting with their clients. If there was a problem with a client, especially prevalent in the labour ward when the student had been left on her own, the student would ask my advice. Unless it was an emergency, I usually responded with "I would ask the midwife". I responded in this way not only to remind the student and the staff that I was not part of the system of care but also to ensure the client did not question the practice of the midwife. On a couple of occasions I did intervene by directing the student to fetch the midwife when I became concerned about the well being of the fetus. On one occasion when I was especially concerned about the condition of the client I fetched the midwife myself. At all other times I placed as much distance as possible between myself and the subject of my observation by placing myself in the furthermost corner of the room.

After the initial three weeks of observations some changes were made to the fieldwork plan. These were as follows:

1) I would only observe during 'active' periods at the clinical site on the assumption that the major portion of clinical teaching would be carried out during this time.

2) I would follow through on all 'active' periods until they were terminated by the subject or unless I was too fatigued to continue.

3) I would interview all the subjects informally whenever possible after an observation to validate my perceptions of the episode.

4) I would include conversations verbatim from the students and their patients whenever possible as some of these appeared to have a significance for the study.

3.8.1 Premises

Before beginning this study it was suggested that I identify the premises from which I was starting in an attempt to recognise and deal openly with them, so as to minimise their

intrusion in the data collection and analysis. The four main premises I began with are as follows:

1) The clinical environment will not be efficient in meeting the learning needs of most students.
2) The use of technology will interfere with the acquisition of some midwifery skills.
3) The medical profession will inhibit the acquisition of skills by students.
4) The clinical environment will create anxiety in student midwives.

3.8.2 Fieldwork Plan

November	1987	Communication with the United Kingdom Central Council
		Indepth discussions with the English National Board
		Communications with Midwifery Schools re-refresher courses
January	1988	Commenced Exploratory Phase
February	1988	Discussion with Senior Midwife Teacher
		Permission received for the Study
March	1988	Discussion with the Patient Services Manager
		Permission received for access to clinical sites
		Presentation of project to senior staff
April 8th	1988	End of Exploratory Phase
April	1988	Discussion with midwifery teachers for access to students
		Discussion with student sets
		Consents obtained
		Selection of 5 students per set
		Obtained student demographics
May	1988	Commenced study of 2 senior sets A and B and junior set C
June	1988	Discussion with and inclusion of set D (new set)
September	1988	Discussion with and inclusion of integrated set, Set E
December	1988	Study observations completed along with informal interviews
		Formal first interviews of midwifery tutorial staff completed
		Some formal interviews of staff
June-July	1989	Remaining formal interviews of staff completed

Second formal interviews of tutorial staff completed
Formal interviews of students completed

A seven month field work plan was drawn up which included the opportunity to observe five sets of five students, each set at a different stage of their training. Two sets were followed from the beginning of their training in June and September, (sets D and E) two senior sets, one at 15 months (set A) and the other at 9 months, (set B) and one set at 4 months of their training (set C). Set D was not followed for the first month because of an error on my part in the timing my observations. This error was not repeated for set E.

Interviews with teaching staff were scheduled for 6 weeks after the commencement of the study in order to validate possible themes already arising from the analysis of observational data. The remaining formal interviews with students, staff and tutors took place six months after the completion of the fieldwork observations in order that a more complete analysis could be done prior to the interviews. This was to ensure that themes which had not been fully saturated during the fieldwork could be validated by content experts.

3.8.2.1 Education

Many changes took place within the structure of the education department during the observational period. After prolonged negotiations the school of midwifery became linked administratively with a school of midwifery from an adjoining health authority. This linkup created a new position, that of Director of Midwifery Education. There was competition for the job between tutors already in the two departments as well as from outside. One of the tutors from the case study site was the successful candidate.

Negotiations continued with other health authorities for further educational links and these culminated in a College of Midwifery and Health Care Studies. The College then sought to align itself with another educational institution in order to prepare for the Project 2000. The latter event were not accomplished during the case study period.

These events were partially driven by a national move from 'service-led' training towards a more educationally oriented preparation of student midwives. Midwifery education, which had previously only had an advisory role in the placement of students, began to achieve autonomy from the service component of midwifery in 1984. This autonomy had been achieved by the case study site during this study in 1988. There were still some health

authorities who placed the education budget in the hands of the midwifery service managers.

Because of the dichotomy between service and education, a senior forum was developed on the case study site to enable managers and educators to meet monthly and pool ideas on midwifery and student practice. Due to the leadership role of previous midwifery managers with regard to student practice it took some time for the two groups to develop a productive relationship.

3.8.2.2 Practice

Midwifery practice had altered considerably in this unit as elsewhere over time in terms of inpatient and community care. The midwife has progressed from being an independent practitioner providing continuity of care to her client to becoming a member of an obstetrical team providing specialised care in one of the following; antenatal care for outpatients or inpatients, care during labour and delivery or postnatal care. In Hospital B a small number of midwives also work in the special care baby unit, two in the fetal medicine unit, three on the isolation ward and one midwife is employed solely to assist women with breast feeding.

During the fieldwork period there was a building project under way to encompass the admission of gynaecology patients from a hospital linked with the site through postgraduate medicine. This hospital was due for closure as soon as the move was completed. The building changes caused considerable upheaval with noise, dust and obstruction of traffic, both inside and outside the hospital. The changes made delivery of care very difficult as it was often so noisy that fetal hearts or bloodpressures could not be monitored without resorting to technology which was in short supply. As a result, many of the staff became quite short-tempered especially when the counselling or monitoring of patients was interrupted by prolonged bursts of drilling.

Two projects were also introduced into the field at the same time by the department of midwifery education. The first was the introduction of the concept of mentorship which was initiated shortly before the beginning of the fieldwork. The midwifery teachers felt that having one midwife assigned to each student in each clinical area would provide the student with more guidance, teaching and supervision by the clinical midwives. However, although the teachers had explained the concept of mentorship to the midwifery managers they had not discussed it with the midwifery staff and had left such explanations to the

managers. During the fieldwork period it became clear that there was considerable confusion about mentorship, with each unit applying the concept in different ways.

The confusion surrounding mentorship frustrated the students who were supposed to be part of the project. Students were provided by the ward sister with the name of a mentor in the clinical area but rarely worked with them. In areas such as labour ward the mentors selected were often on different shifts from the students and some were even on holiday during the student's placement in their area. As a result, there was little change in the teaching behaviours of midwives. The students had expected an improvement with the introduction of mentorship and so they were left feeling confused and frustrated.

The second project, team midwifery, was discussed frequently during this time and at all levels of midwifery practice but was never initiated. This project was an attempt to move away from the specialisation of midwifery to provide the client with continuity of care. It came about partly as a result of women's complaints about the number of midwives they were exposed to during pregnancy. Team midwifery involved a small team of midwives caring for a client from the antenatal period through labour, delivery and the postpartum period and into the community (Flint, 1986). It was thought to be a positive response to such women's complaints as well as providing midwives with a more comprehensive role. Many midwives had felt they were losing their skills by remaining in one clinical area for a prolonged period of time (Robinson, 1989b). Logistically this project proved troublesome, because although midwives wanted change, they were resistant to the implementation of change and this particular project. One of the reasons for their resistance could have been that many changes were occurring at the same time, leaving the staff feeling overwhelmed.

Community practice had also undergone considerable change over the years. The move towards a 100% rate of hospital confinement brought about by the Peel Report (H.M.S.0, 1970) had changed community practice from care throughout pregnancy and parturition to mainly postpartum care. Less than five per cent of births happened at home, even less in the locality of this case study site (Campbell and Macfarlane, 1987). Domino deliveries were introduced to enable the midwife to maintain her parturient skills while still providing a hospital environment for the client. 'Domino' was the acronym for 'domiciliary in and out' and involved the community midwife providing antenatal and postnatal care for a woman in the community but taking her into the hospital for delivery. Increased hospitalisation

led to shorter hospital stays because of the increased demand for beds. As a result, the main emphasis of the community midwife's work became care for postpartum women.

Community midwives attended antenatal clinics attached to G.P.'s offices. In some of these clinics they had full autonomy while in others they assisted the general practitioner. The midwives were begining to increase the rate of homebirths and domino deliveries but this has been very slow (260 domino's and homebirths in 1989 amongst 20 midwives). Part of the difficulty was the active discouragement of home births by many G.P.'s and part the midwives' reluctance to take on the responsibility for a birth in the home.

3.8.3 Sample Characteristics

Initially a total of 26 students were observed during the fieldwork. The extra student was the result of an error due to two students having the same surname. I determined to keep this number of students until one of the students with the same surname became pregnant. She was dropped after only two observations because she was frequently absent due to illness. If she was on duty she was always having to excuse herself to her clients because of morning sickness. This left a total of 25 students for observations and informal interviews. Twenty five midwifery staff and teachers and 14 students were interviewed on a semi-formal basis and twenty six students on an informal basis.

Study Site: Number Observed and Interviewed

Subjects:	No Observed	No of Observations	No of Ss. Interviewed (formal & informal)	No of interviews (formal)
Students	26	(see Appendix K)	26	12
Tutors			8	13
Staff			20	20

3.8.3.1 Sampling Techniques

The sampling was based on the researcher's judgement concerning the type of sample able to provide the most comprehensive information for the study (Wilson, 1985). As such it was a non-random, judgemental or purposive sample. An attempt at some objectivity in selection was made by the use of a random selection technique from among those students who volunteered to participate in the study.

Students were provided with information about the study on their study days and were given the opportunity at this time to participate. A paper was signed by those interested in participating and returned to me by the tutor of the group. If more than five students in the set volunteered I drew lots for their names. I knew none of the students although I had seen a few during the exploratory phase. In set D there were only 5 students and they all signed. In the remaining sets the participation rates were 60 % for set A, 52% for set B, 65 % for set C and 60 % for set E.

3.8.3.2 Student Demographics

The sample was fairly homogenous in terms of age, education and previous training.The age range was from 22-28 years with an average of 24 years. Educational standards were quite high and many of the subjects had at least two 'A' levels. No one had less than five '0' levels and the average was seven. This was not indicative of the standards for all midwifery schools. One of the reasons for the high standard at this school was the reputation it enjoyed for obstetrics. All students were trained nurses with the majority having done no other courses. Four of the students had advanced to a sister's post while the remainder had worked as staff nurses prior to entry into midwifery. All but one of the students was single at the beginning of the study but two others married during the fieldwork period.

The majority of the sample were Caucasian English (9). One student was from Scotland, 2 from Wales and 7 from Eire. There were 2 Carribean-English, 1 Greek-English, 1 from the Channel Islands, 1 from New Zealand and 1 from Australia. Ethnically, the student sample was not representative of the ethnic groups of the hospital staff. Statistics were not obtainable on the staff but from fieldwork observations there was a much larger proportion of the Asian and Carribean population represented than was evident in the student sample. (See Appendix E for more details).

3.8.4 Researcher Effects on Subjects

Initially, reactive effects of the researcher on the subjects and other staff were noted as a result of my presence in the environment. An attempt was made to reduce this by reiterating my purpose for being there. However, only the passage of time appeared to have an effect on this phenomenon. After a period of two to three weeks (depending on the student and staff) this ceased to be such a problem. The factor that appeared most important in reducing this phenomenon was the frequency of my association with the parties concerned. If the association was infrequent the reactivity appeared to be

prolonged and in some situations, as with some of the medical staff, it remained throughout the study.

It became increasingly obvious to other staff as well as myself that my presence affected the medical staff in a variety of ways. One senior registrar appeared to feel threatened by my presence, making frequent comments relating to my purpose for being there. If I did not reply immediately many of the staff would make supportive comments on my behalf. Even the students would make jokes and attempt to pass off the incident with humour. I would also attempt to reduce the tension with a joke.

Another registrar informed me that she was teaching the students much more as a result of my presence. She stated that one night on the labour ward when she was feeling bored "I suddenly thought of you and decided I could relieve my boredom by asking the student what she knew. Anything is better than boredom and you know, she really surprised me and herself with what she knew. It was really good". I also noticed one of the house officers giving a detailed description of a vaginal examination she had just performed to the student I was observing. After she had left the room the student spontaneously informed me that "she has never done that before. Usually she doesn't bother". One of the anaesthesiology registrars told me he had not thought about teaching the students until I began my study. I did notice that whenever I had a student under observation and he was present he was very conscientious about teaching the student.

3.8.5 Case Study Observations

The first observations tended to focus on the student's behaviour and interactions with other staff and clients. I found myself concentrating on every detail in the environment and writing down all that I could. I was so busy writing that it is possible I may have missed important cues. As my skills in observation and abbreviated documentation began to improve I was better able to select and focus on the more pertinent information. This selection included the addition of more peripheral information and verbal content. Verbal and behavioural interactions as well as site data were also included. Upon perusal of my notes I found the earlier lack of data on the environment compromised the analyses of that collection of data.

With more exposure to the clinical environment I found I was able to analyse and select more meaningful information. However, this skill took two to three weeks to acquire and, in the beginning, I was inundated with data which had little real value to the project. A

further problem was the fatigue that I experienced in the beginning as a result of focusing on so many stimuli. After fieldwork observations I often felt too tired to transcribe or read through my notes. The fatigue did begin to improve with further exposure to the field and I eventually determined that it had been due to data overload as a result of poor selection of meaningful data.

Another change which began to appear at about the same time was an improvement in my memory. I had found at the beginning that if I did not transcribe my fieldnotes within 24 hours of the observation I had gaps in my fieldwork activities. This was because my notes had often been abbreviated to the extent that they were incomprehensible. The retrieval ability of my memory proved to be inadequate in providing cues to some of the interactions. With the passage of time I noted that not only did my memory retrieval rate improve but I was able to retain larger chunks of the data. This was extremely helpful on the days when I felt too fatigued to transcribe my notes.

3.8.5.1 Reaction of Subjects to Observation

Students were initially very apprehensive as were many of the staff. Some subjects would greet me with "Oh you're here. I thought you had forgotten me". I would follow up on such statements with an offer to withdraw if they felt it necessary. Fortunately, no one took me up on the offer. The majority reassured me that it was not a problem and they just had "to get used to you being around". One student did not refuse to participate but always seemed to be off sick, not available or "unable to handle you today."After several such episodes and only two observations I discontinued her from the sample. She had been part of the set that consisted of only 5 students and as the others had agreed to participate she may have felt that she could not refuse.

After the initial apprehension most of the students seemed to adjust quite quickly to my presence, some much quicker than others. After only three observational episodes with one student, she had adjusted to the point of forgetting that I was there. When I spoke to her after the client had left the room she gave a visible start and exclaimed "Oh, I'd forgotten you were there. You did startle me". Others took a little longer to become comfortable with my presence and respond to the environment in a more 'natural way'. One student never really seemed comfortable in my presence. However, she insisted upon continuing with the study when I offered her the option of leaving. I did note on subsequent observations that this student had problems interacting with many people and complained in her interview of 'personality problems' with some of the staff.

Many of the students were interested in what I was writing during my observations but only two expressed a desire to read my notes "just to see what you have written about me". I explained that I was unable to let them do so as the notes were confidential, containing information on all the people in the field. I then reiterated my promise to share the findings with them. Although they appeared not to be satisfied with the response, they did accept it. None of the students expressed any concern about the information getting back to the school or the managers even though they were very frank in their interactions with me.

3.8.6 Case Study Interviews

3.8.6.1 Informal Interviews

Informal interviews were carried out in the field when possible after each observational event. This was to provide clarification and validation of the researcher's perception of the event and provide some objectivity to the transcribed interaction. Chenitz and Swanson (1986:88) suggest that the use of observations with no informal interaction on the scene not only decreases validity of the data but also cannot be sustained long by either party. Informal interviews did assist in sustaining the interaction between myself and the subject and also helped me to discover the range in congruency between their perceptions and my own. It also provided me with data on the congruency between the subject's perceptions and what I deemed to be reality. More than one informal interview was undertaken during prolonged observational events.

3.8.6.2 Formal Interviews

Although some interviews were undertaken during the fieldwork the majority were done in June and July of the following year. An interview guide used during the fieldwork was expanded for the later interviews to include other themes identified during analysis. The guide was used to provide not only flexibility and latitude in asking and sequencing questions but also to ensure the same general topics were covered with each subject. The guide was created from the data collected during the exploratory phase but refined after fieldwork had begun. (See Appendix B).

The formal interviews carried out in Year One of the study period (1988) were used as verification of the data by the procedure known as theoretical triangulation. The interviews were used to verify the findings from the observations and also to provide some saturation of categories already identified from the analysis of the observational and

informal interview data. The second set of interviews in Year Two (1989) were used to verify the substance and properties of the categories already identified from analysis of the fieldwork data. As identified earlier I was unable to stay in the field until all of my categories had been saturated therefore this opportunity was used to verify the concepts and constructs identified in the categories.

i) Students

Two to three students were selected from each of the sets of students in the study for formal interviews. This provided a total of fourteen formal student interviews. Most of the students were willing to participate, even those not in the study, because they saw it as a way of getting things 'off their chest'. However, only students who had previously participated in the study were formally interviewed. All of the interviews were tape recorded and transcribed at a later date. There was not always a choice of students for interviews because some of those who had completed their course by the following June had already left the institution.

ii) Teaching Staff

Teaching staff ranged in age from 34-59 years. They had a variety of experiences but only one had worked in another country. All of the teachers had the additional qualifications of the advanced diploma in midwifery and the post graduate certificate in education. One of the two clinical teachers had a certificate in education. Many of the teachers were undertaking further studies. Three were enrolled in baccalaureate programmes and two in a master's programme in education. One already had a graduate degree in science.

Interviews were undertaken with all teaching staff and one clinical teacher during the fieldwork period to explore areas of similarity and difference between educators and service personnel as well as to obtain their assessment of student expectations and functioning in the fieldwork environment. Four teachers were interviewed a second time the following year to provide content validity of the themes which had emerged from the data. Areas of interest arising from the initial interviews were incorporated into the guide for later formal interviews.

There was consensus among teachers in all areas of education except in the area of the relationship between education and practice. Some teachers believed a dichotomy existed while others did not. Of those who believed a dichotomy existed, some felt the effect on the student was minimal while others felt the effect was serious. During the fieldwork

period two teachers left and were not immediately replaced. Another teacher had long absences due to sickness.

iii) Midwifery Staff

Interviews with staff began in November 1988 (Year One) but few were completed before the end of the observational period. A minimum of two staff were selected from each clinical area for the interview. Staff members were not identified prior to the interview the selection being made by convenience. Whoever was on duty at the time that I visited the unit was approached. Occasionally the unit would be too busy for me to obtain subjects on that day and I would arrange with those present to return at a more convenient time.

The majority of interviews were tape recorded. Refusals included two of the sisters and one staff midwife. One sister refused to be interviewed but kept finding staff members that she could 'volunteer' for this project. The remaining two agreed to be interviewed providing I did not tape record them. However, I found my notes to be incomplete and not too useful because I was not able to write fast enough to note all of the points or to follow up on themes.

3.8.7 Interview Problems

There were many problems, initially associated with tape recording, (such as forgetting to switch on or defunct batteries). Early interviews were recorded during a very hot period of weather and the heat caused the recording mechanism to stick at times. Initially I used a voice-activated recorder but found that it often failed to be activated when the subject had a soft voice or turned her head away. As a result I changed this model for the more traditional but reliable type of recorder. Interviews done during the observational period of 1988 (Year One) were not as problematic as those done in June of 1989 (Year Two). This was because the interviews done in 1988 were taped during the winter months when windows were closed and external noises were reduced. In June 1989 it was very hot and windows and doors everywhere were wide open. The external noises of traffic, internal drilling and hammering, intruded to an extent designed to test the endurance of a researcher and those subjects undertaking interviews. Because of time constraints I had taped many interviews before I began the work of transcription. Transcription became even more of a time-consuming practice as I had to replay the tapes many times in an endeavour to retrieve the data for which I had little memory.

Many times interviews would be arranged but were unable to proceed because of admissions of women in labour or those recently delivered. Labour ward and the special care baby unit were especially difficult because their busy episodes were more frequent and lasted for much longer periods than those elsewhere. The labour ward had a large number of deliveries during June and July 1989 and the special care baby unit admitted many small, preterm babies.

3.8.7.1 Reactions of Subjects to Interview

A time and a place for interviews were arranged with the subjects. The majority of the interviews were arranged for the time the subject was working in the unit because many of the staff lived some distance from the case study site. The interview was focussed but not uniformly structured and so the same questions were asked of each subject but not necessarily in the same order. The order of the questions changed according to the responses of the subjects. Reactions to the interview varied across groups so I will deal with each group separately.

i) Students

The majority of students appeared quite comfortable with the interview and recording of their responses. Some even suggested improvements in the recording technique, such as holding the microphone closer to their mouths in an attempt to reduce the intrusion of external noise. I believe they felt comfortable because of the rapport we had built up over the eight months of observation.

I began the interview by outlining the study and telling the students that the focus of the interview was upon their clinical experiences. Some students would respond to this statement as if it was a question. If this occurred I just recorded the information and then went back to the question. (See Appendix B).

A couple of the students were apprehensive about the recording in the early stages but this seemed to disappear as the interview progressed. Occasionally a student would end a response with the question "Is that the right answer?" and I would restate there were no right or wrong answers I just wanted to gain an understanding of their experiences. All students were reassured of the confidentiality of the data and its destruction at the completion of the study.

An additional problem with the interviews was the difficulty of providing the participants with open-ended questions while attempting to verify my themes. Although my perception was that the approach was flexible and open to the participants interpretation some questions ended up being more closed than I had at first suspected. I can only conclude that this was partly due to my inexperience with the techniques of interviewing and partly due to my eagerness to validate what I perceived to be valid categories. Again, there is the possiblity that the data has been compromised because of this approach.

ii) Teaching Staff

The teaching staff were very factual in their responses to the questions. Some gave very short responses while others expounded at great length. One or two mixed facts with hypotheses which were generally stated in the form of, "I think ...." or "theoretically ...". Although a couple expressed a little apprehension concerning the recording, it did not manifest itself in the responses. One teacher who took a little time to 'warm up' was in full swing when I discovered that the tape recording machine had not been functioning for the last ten minutes. Unfortunately, when the tape had been fixed she had lost track of her theme and her original responses were lost.

iii) Midwifery Staff

A more detailed description of the study had to be provided for the midwifery staff as many of them had not previously been involved in it. They asked many questions about the study but these were not recorded unless they came after the interview had commenced. When I arrived on the ward the midwife would tell the ward sister that she was going off to be interviewed. Although they did not ask permission to leave, I asked the ward sister for permission to take them away from their duties for this purpose.

Some of the staff appeared apprehensive about the tape recording but not the interview. However, as the interview progressed and they became interested in the subject, this apprehension disappeared. Many of them would preface their responses with, "I'm not sure what happens here but I remember when I was a student...". For some members of the staff the interview seemed to provide a cathartic experience.

Only one sister and one midwife refused to be recorded but were willing to be interviewed. Only one sister refused both. I did interview the two who refused the recording but found it very difficult. The process was extremely slow and I think it inhibited the subject because of the time factor. I also found I was missing behavioural

and verbal cues because of the need to write notes as fast as possible. In retrospect if this occurred again I would arrange for the interview when the subject was not on duty This problem helped to emphasize for me the value of recording interviews.

The interviews varied in length from 25 to 45 minutes. The midwifery staff tended to talk for 25-30 minutes. Some subjects, such as some of the students, would open up immediately and looked quite disappointed when I terminated the interview. Before terminating, I always asked the subjects if there was anything that they wanted to add. Most of the students and some of the teaching staff usually did. The majority of the ward staff appeared quite relieved when the interview was over and very few added anything at the end. Most of those interviewed were very frank but did not express any concern about the confidentiality of their disclosures.

3.9 The Research Process

It may be helpful to first summarise the research process before going on to discuss the research instrument. Students were observed in all clinical areas for the period of time that it took for them to complete a skill, such as booking a woman or delivering a baby. The length of time taken by an observation varied from one hour to eight with the average being two hours. When possible all observations were followed by informal interviews with the students to obtain verification of what I believed I had observed and the meaning of the event for the student. Transcription and analysis was ongoing with the collection of data, and as themes and categories were identified more data was collected from different sources to saturate the categories.

I found on first entering the field that although I had identified some themes from my refresher course I did not use them as a focus. I believe this was because I had not previously experienced the exclusive role of the participant observer, not involved in everyday practice. As a result I felt overwhelmed with all the events happening in the field and came away with voluminous notes which were difficult to transcribe and analyse. I transcribed my notes with large margins on the right hand side in which I could write memos on ideas that came to me while transcribing as well as during the analysis. On the top of my notes I wrote my code for the student, the date, how many months she had been in the training programme, the shift she was working and the clinical area.

My initial content analysis of my transcribed notes was superficial and the themes which emerged bore little relationship to the categories which finally emerged. I examined each line and compared it with other lines to identify parameters of thoughts and ideas outlined in the data. The first notes I took were not too informative because I had attempted to write down everything that was happening and the detail was insufficient to obtain many clear ideas. However, after only four observations and informal interviews I found my note taking had improved and my observations had become more focused. My observations became more focused as a result not only of my initial analysis of my notes but also because I appeared to make many connections at a subconscious level.

The first notations made were along the lines of 'student does not appear to know basics', 'student does not have skills and knowledge for the role,' 'midwife guarding knowledge' 'control', 'ambiguity in role', 'conflict with role,' 'technical skills' and 'stressful environment', to name a few. At approximately two months into the fieldwork, I ended up with over 100 themes which did not seem to be connected in any way. I began to despair of ever placing these into categories. Some of these themes related to treatment of clients and client vulnerability. All themes were further analysed but those not considered relevant to the study focus were placed on one side for analysis at a future date.

I wrote down all of the themes and further analysed the data with these in mind. I then went back into the field with these ideas in mind to collect more data. After further analysis which appeared to take longer than I had expected as it involved both manifest and latent content analysis a picture began to emerge. To provide an example of what I mean I will discuss the emergence of the first category which became the core concept of my data. This concept is the one I have called verbal communication.

I first noted on observing a student in the antenatal clinic that she was asking the client questions without paying attention to the underlying content of what the woman was saying. In addition I noted very little health teaching being provided even though the opportunity was there when the student asked questions, such as 'do you smoke?'. The questions she did ask were directive and followed the format of the case notes. There was little evidence of original thought or appropriate responses to the client's questions. Having identified these ideas, which at the time I connected with the students's level of training (she was a junior student) and not communication I began to focus more on the student's practice. With the focus on practice I began to observe for how she was taught and in what ways.

I began to note that students were often left on their own with little teaching and that when information was provided it was often inappropriate or inadequate. From my analysis, and at this time cursory documentation of verbal exchanges, I began to perceive a link between teaching and verbal communication. In retrospect this sounds a little strange as it would appear logical to assume that the two would go together. However, I was unfamiliar with the literature on verbal communication and therefore the problematic communication which I identified came as quite a surprise. When I reentered the field I not only observed for teaching and learning but focused specifically on verbal communication and its presence or absence in teaching. Originally I had written down very little on what was verbally communicated but I now began to make a conscious effort to do so. As a result of further manifest analysis I began to see a pattern emerging. These patterns were placed under headings such as 'student requested information but it was/was not provided by the midwife', 'taught by midwife but information incomplete', 'midwives using terminolgy with students', 'students providing incomplete information to the client', 'students obtaining information by indirect means'.

More data were collected on these themes until I felt that no new themes had emerged along the lines of verbal communication. Despite the obviousness of the concept of communication as a category I still had not identified it as such at this stage. I continued to gather data which began to also present a picture of role difficulties as a result of ambiguity, conflict and stress. It was at this stage I began to consult the literature for information on verbal communication and came across Kirkham's (1987) study of midwives in the labour ward. Her study, which focused on information-giving to women in labour, identified verbal communication blocks which she called verbal asepsis. These blocks I had already identified in my own data as occurring between midwives and students as well as between students/midwives and their clients. I then read Benner's (1983) work on student nurses, 'From Novice to Expert' and this provided me with the term 'maxims'. This term was used to describe the cryptic information one expert nurse will provide another which can only be understood by another expert nurse working in the same speciality. I had already noted that some midwives used this type of communication when teaching quite junior students who were clearly unable to comprehend the content. Therefore, the literature not only supported my data analysis in this area but also gave me the labels for the properties of my category. The indepth perusal of the literature was done after I had left the field.

Once I determined that my data fell within the themes identified by the literature I again used the constant comparative method of analysis. This comparison of data within cases and across cases, as well as line by line was to ensure that the individual themes were mutually exclusive and did not fit into any other category or theme. This method of analysis also assisted me in seeing a larger pattern for the themes as well as identifying other themes not previously noted. It was at this time I realised I would need two other headings for the data which did not fit the headings of maxims and verbal asepsis. These headings became auditory asepsis and appropriate verbal communication. After I had named my verbal data and placed it into mutually exclusive boxes I realised they were all part of the larger concept of verbal communication.

Not all of the categories were identified in this way. The theme of socialisation was identified quite quickly once I had found that role difficulties was a recurrent theme in the data. I think this was because I had prior knowledge of this area and therefore was able to make the connection much more quickly than I was with verbal communication. However, although the theme was identified early the properties were not fully developed because of time constraints which prevented me from saturating this category and thus developing all of its properties. Analysis of the data which was quite intensive and associated with constant perusal of the literature helped me to search out this and other categories and their properties.

After I left the field analysis of the data continued for a further six months. Following the final analysis of the data I returned to the field five months later to complete the formal interviews. These interview questions were formulated from the data and used to verify the categories. These data were further analysed with the aid of the constant comparative method and the literature. Even during the writing-up period more analysis occurred especially with regard to the theoretical propositions.

Despite the usefulness of the constant comparative method in helping to identify the exclusiveness of categories it was not always successful in separating out their properties. One example of this was the use of humour in stressful situations. While humour would be considered by many to be a comunication tool I eventually placed in the category of anxiety and coping as I felt it demonstrated a common method of coping with stressful situations. This was a decision that I as a researcher had to make and another researcher may not have made the same placement. Methods to verify the categories and emerging theory and to ensure the reliability of the data have been addressed in chapter two

3 9 1 The Research Instrument

As the main research instrument for the collection of observation and interview data, I needed to maintain an unbiased but reflective approach to fieldwork. A pertinent question in this respect was, as a midwife and part of the culture observed, is it possible to maintain such an approach? Would a psychologist or sociologist provide richer, unbiased data because they are not a part of the culture they are studying? I do not believe so. One of the problems that I encountered was the need to participate occasionally in order to gain credibility as a researcher. In turn this credibility gained me access to observational and interview data which may have otherwise been denied.

Miles and Huberman (1984:48) postulate that an individual educated and trained in a single discipline can produce naive and data-overloaded research. They refer to Margaret Mead's study in Fiji as a case in point. They believe that the problem of getting beyond the superficial to become 'empirically literate' is functionally and conceptually easier for an individual with a multidisciplinary background. They further postulate that inexperience and single-discipline grounding can lead to the danger of putting a ready-made explanation on phenomena which might be construed in better ways. I would argue, using a similar logic, that a researcher not familiar with a profession such as midwifery, might also spend time gathering useless data because of the lack of knowledge of what is important and an understanding of the behaviours involved.

In qualitative studies, issues of reliability and validity ride largely on the skills of the researcher. Therefore, the question of how relevant am I as an instrument is a crucial one. Miles and Huberman (1984) suggest that the best qualitative researchers should have the following characteristics:

i) Some familiarity with the phenomena and setting under study.
ii) Strong conceptual interests.
iii) Multidisciplinary approach as opposed to a narrow grounding in a single discipline.
iv) Good investigative skills including the ability to draw people out and to ward off premature closure.

My own background of nursing and midwifery can be described as multidisciplinary because both professions draw heavily on both the sciences and the humanities. My

educational background is both eclectic and multicultural. My earlier education and professional training was undertaken in England and my formal university education undertaken in Canada. My undergraduate degree was in biological sciences with a minor emphasis on psychology. My graduate degree was in nursing with some coursework in business studies. The latter courses placed a heavy emphasis on sociology.

My graduate thesis used a sociological framework to investigate role conceptions and their relationship to job satisfation in nurses. As a midwife, removed professionally and culturally from this research topic, I believe there was enough distance to provide as unbiased an approach as is possible under the circumstances. However, my midwifery background does provide me with a refined, ecumenical and economical approach to the collection of data (Miles & Hubermain, 1984:48).

3.9.2 Use of Documents

Information from documents was obtained for a variety of reasons. The content of the curriculum and its relevance to the student's stage of training was important in order to gain an understanding of students and education staff expectations for the clincal placement. Information on the heirarchical administration structure provided knowledge of the impact of that system in the service area.

Policy documents were perused for the effect they had on the service area in general. Each ward in the hospital devised its own policies for the guidance of midwifery staff. The less experienced staff treated the policies as if they were 'law' and followed them literally. Because the policies were formulated mainly by the medical staff (one midwifery manager was on the policy-formulating committee) they impacted on the autonomy of the inexperienced midwife. This lack of autonomy and responsibility was evident to the students who felt frustrated by exposure to this type of practice. Experienced and confident midwives tended to practice without reference to the policies unless they were in an unfamiliar situation. The impact organisational policies made on students and midwives will be discussed in Chapter Seven.

Documented information on the numbers of midwifery staff, medical staff, deliveries, medical interventions, patient admissions, outpatients and community visits not only provided contextual information but also provided evidence of the range of experiences available to the students. All documentation was provided freely upon request. The

explanation of 'research' produced a very cooperative effect from all midwifery, medical and administrative personnel.

3 9.3 Organization and Analysis of Data

3.9.3.1 Observational Data.

Any encounter between myself and a subject was deemed to be an observational encounter (Denzin, 1978). I would present myself to the subject in the clinical area, find myself a chair and sit with my notebook in full view of the occupants, recording interactions as they happened. Notations were made and field notes added when relevant. Fieldnotes encompassed such things as feelings of irritation and fatigue, and problems or difficulties encountered when documenting observations.

Subjects were identified using a numerical system for their set and an alphabetical letter for their name. This was to ensure confidentiality if the notes were lost or mislaid. It was also a helpful precaution in the event of someone looking over my shoulder to read my notes which did happen occasionally. In the subsequent descriptions of the students' interactions the coded system was replaced by fictitious names.

Data were transcribed as soon as possible after the event. This could vary from a few hours to one week. Every attempt to shorten the period was made but given the time constraints, more information was amassed that could be transcribed at one time. As the study progressed and increasing data were amassed, the time intervals between the observational episode and the transcription became longer, though at no time exceeding one week. Some rudimentary analysis was possible during the transcription and these notes were placed in the right hand margin of the transcription.

The transcribed material was hand written covering two thirds of one side of a sheet of paper. The right hand side of the sheet was left blank for analytical notes. Demographic information on the subject as well as on the context was placed at the beginning of each transcribed episode. During the preliminary stages of analysis the relevant data were underlined in red and notations on their emerging themes made in the margin. These themes were later placed into categories.

The initial manifest analysis was centered around key words and phrases which I felt addressed the study question. As I became more familiar with the material and more adept with the analytical procedures latent analysis became the dominant procedure. Latent

analysis was used to extract the symbolic meaning of encounters for the students as these meanings emerged from the data.

Additional latent analysis, known as the constant comparative method, was done in a stepwise fashion as outlined by Glaser and Strauss (1967) for the production of grounded theory. For this process each phrase, line, paragraph and statement in the fieldwork data was compared with every other piece of data in order to identify what concepts were reflected in the fieldwork material. These concepts were subsequently coded and each code was compared to other codes within the same interview and observational material and across interviews and observational data. The same procedure was carried out across participants for comparison and verification. Similarities and differences were noted and related codes were clustered into categories (Jordan, 1990). Through constant comparison core concepts were identified which consistently, validly and economically allowed classification of data into conceptually relevant categories. A relationship was sought between categories in order that hypotheses could be formulated and theoretical propositions identified (Glaser & Strauss, 1967).

3.9.3.2 Interview Data

A longer time elapsed between interviews and data transcription due to the overload of observational data. Some interviews were not transcribed for several weeks. Transcription and analysis proceeded along the lines of that for the observational data.

Interview data proved to be much more time-consuming than the observational data because of problems already identified, such as external noises drowning out the speaker, tone changes or movements of the subjects's head which caused muffled responses to be recorded. There was also a problem of understanding dialects and accents. It became obvious to me during the transcription how dependent I had become on behavioural cues and eye contact for full comprehension of verbal interactions. As a result, I had to replay tapes several times in order to identify words and meanings for transcription.

3.10 Perspective of a Participant Observer

The participant observer is always on stage, not only in observing others but also in monitoring the responses others have to you (Dingwall, 1977). Part of the problem is the fact that credibility has to be achieved without compromising observer status. This proved

to be quite a problem in the field. I was frequently asked about my background and when I stated I was a midwife it appeared to provide a general acceptance of my status.

Initially, I believed this acceptance to be useful as it allowed me access to areas and situations from which I may otherwise have been forbidden. However, it later proved to be a problem especially with one particular sister who frequently expected me to "look after that student as you are in there." Several times I reiterated my purpose for being there and that it was not to supervise students. This seemed to have little effect because she would say that she would send someone in but usually no one appeared. This created a dilemma as I was concerned that if I was any more forceful I would lose the cooperation of the staff.

A second sister, when given the supervision of a student that I was observing, would tell the student to call her if she needed her and then would disappear. She would only reappear to relieve the student for meal breaks. The same sister when asked twice by the student to come and check on a patient, did not appear. I advised the student to ring the emergency bell which she did. Another member of the staff came. This was the same sister who had been willing to be interviewed but had refused to be tape recorded.

It was quite clear from these situations that there were problems with participant observation in terms of subject reactivity. However, such reactivity was useful in identifying behavioural patterns that were used in other interactions. The sister who refused to be tape recorded also demonstrated a lack of confidence in the supervision of a student when exposed to the presence of an observer. The midwives who were confident in their interactions with students were also confident in their practice and appeared to be unconcerned by my appearance. Midwives who were less confident in their practice were less confident with students and in their interactions in my presence.

Summary

The design of the study for the collection and analysis of data provided information of the quality and depth required to answer the research questions. The use of methods such as observations and interviews allowed flexibility in the fieldwork which enabled the development of themes which had not been evident in the exploratory phase. Two difficulties noted with these methods were the amount of data produced and the fatigue of obtaining, transcribing and analysing such data.

The description given on the case study site and the administrative environment provided an insight into the types of experiences available to the student and the restrictions inherent in the system. It also gave the evolution of the midwifery training school and the impact of medicalisation on the school's present functioning. The amount of congruence between students' perceptions and those of others, such as the educational and administrative staff was also identified.

Although there were problems of subject reactivity these could be viewed in a positive light in that they added additional data on subjects' behavioural patterns. Midwives confident in their practice were less likely to be negatively affected by an observer than those with less confidence. Many of the students appeared to find the interviews a cathartic experience and it is possible that in that context they may have reduced student stress.

Limitations of the fieldwork methods, such as leaving the field before all categories were saturated and too much structure to the interview schedule were discussed in light of the bias they might add to the data analysis and verification. The principles of grounded theory were used in the analysis of data in order to identify important concepts and to sek out their relationships.

The next chapter will discuss specific themes identified in the study in relationship to the clinical environment. Socialisation of the student to the clinical area will be discussed along with student selection, difficulties with role transition and the requirements for social survival.

CHAPTER 4

THE CLINICAL ENVIRONMENT

This chapter will describe the clinical context in which the student practised her skills and sought to obtain the required clinical knowledge for the practice of her profession. Information on the context is provided to enable the reader to obtain a perception of how it affected students' interactions. Some of the general themes that emerged from the analysis of the data will be discussed. Specific themes, codes and categories will be dealt with in the following chapters.

Kolb (1984) suggests that experiential learning is learning which is rooted in our doing and our experience. This type of learning provides direction for making judgements as to the choice of action required. Experiential learning, referred to in this study as the acquisition of clinical knowledge, is gained over time. Benner (1984) suggests that the novice in the clinical area is often unaware of the gains. Discussions with students during observations in this study support this view.

Benner (1984) goes on to say that expertise develops only when the clinician tests and refines propositions, hypotheses and principle-based expectations in actual practice. In this context, clinical experience is a prerequisite for expertise or competency. To obtain a view of the complexity of the clinical experiences that student midwives are exposed to, it is necessary first to provide a description of the environments and the role of the midwife in them.

The different types of clinical environments will be described in detail in terms of their purpose and the interactions they encompass. The clinical environment was identified as a major factor because of its effect on learning opportunities experienced during the exploratory phase of the study. The environment not only varied in the number of learning opportunities that it provided but also in the amount of stress that it engendered. It is suggested as a result of personal experiences in the same environment that too much stress in the clinical area could and would inhibit learning in some individuals.

The description of the environment includes a general identification of the type of stressors that could be encountered by the student. These stressors were identified from my analysis

of observational and interview data. They are provided here without anecdotal support because I wish to convey to the reader a general impression of the environments in which the students worked and the varying levels of stress to which they perceived themselves to be exposed. All of these stressors are discussed later in the texts as they pertain to specific students and anecedotal support is provided at that time. The types of environments in which students were observed were; the community, antenatal clinics, postnatal wards, antenatal wards, the labour ward and the special care baby unit.

4.0 Overview of the Clinical Environment

4.1 Community

4.1.1 Description

For the community midwife the day began in the community office situated in the hospital. The office contained information on all the women requiring antenatal or postnatal visits from the midwife. This was also the location where students met their midwife, obtained details on the women they were to visit and from where they were taken out into the community. The community midwives were responsible for a geographical 'patch' and visited women within that area. The majority of visits the midwife was required to do were those for women recently delivered and discharged from hospital. If she had time she would often visit the women while they were still in hospital so that she would be a familiar face when she called upon them. The midwives also provided antenatal care to women receiving obstetrical care from any general practitioners within that same geographical area.

Midwives worked in teams of six each with a team leader. This was to ensure some continuity of care was provided by a specific group of people available and known to a client when the client's midwife was not able to visit the clients on her own case load. The midwives in the team also took on each other's antenatal clinics when the need arose, such as if the midwife had been up all night with a delivery or was off duty.

During the first hour at work, from approximately eight thirty a.m. to nine a.m. meetings were held to provide continuing education, to discuss new policies, administration or to air grievances. The teams would hold discussions on their clients and client case load and would also provide teaching sessions for students. After planning the community visits with the midwife the student would then go to coffee. On her return she and the midwife would start out on their day's work.

In the event that the day began with postnatal home visits, the midwife would prioritize the visits, either by proximity to each other, or by the urgency of client needs. Upon entering the client's home, she would retrieve the records detailing the client's intrapartum and postpartum period in the institution. After perusal of the documents she would examine the mother and baby, giving advice as required. The baby would be weighed on specific days as determined by the midwife and dependent on such factors as the birth weight, method of feeding and the mother's expertise. A blood test was usually carried out on the baby on the fifth to sixth day after birth to assess it for genetic diseases, such as phenylketonuria (P.K.U.), galactosemia, thalassemia and hypothyroidism. This scenario would be repeated for all home visits. On the client's tenth postpartum day the midwife would assess her for discharge from her care to that of the health visitor. If the client had physical or psychological problems at this time the midwife would continue giving care for a further 18 days at which time the care was transferred to the health visitor.

If the midwife had an antenatal clinic, and most midwives had at least two a week, these were held either in the doctors' offices or in health centres. The client's records would be held in the clinics and retrieved for some midwives by the clerical staff. In other clinics the midwife would have to locate the records herself. Appointments would be given at some clinics while at others women were given a general time in which to attend. It was rare to find 'drop in' clinics amongst this group of midwives.

After being called into the room by the midwife, the client's urine would be tested, she would be weighed and her blood pressure taken. She would then be examined by the midwife for growth of the fetus (fundal height was estimated as a gross measure of growth), fetal presentation and the position of the fetus in relation to the woman's abdomen. Physical parameters were assessed, including examination of the woman's extremeties for any oedema. The woman's blood pressure and urine were also assessed and she was checked for weight gain.

Advice would be offered about diet, exercise, rest and treatment for the relief of any symptoms experienced by the the client. The woman would then be offered an appointment for her next visit to the clinic. If problems had been identified during the visit and were deemed by the midwife to require medical attention the client would be referred to her G.P if he/she was present in the building. If the doctor was not present the midwife would refer the client to the hospital medical staff.

When all home visits and clinics were completed the midwife would return to the general office in the hospital to document her day. This involved filling out details on her clients and logging in the details of her caseload for administrative purposes. If there was any time left she would review her visits for the next day and discuss them with the student. This was also the time the midwife would deal with any questions the student had about the day's activities if they had not been dealt with in the car on the trips between visits.

4.1.2 Stressors

The community tended to be a low-stress area for students because they were rarely left alone with the clients. There was a great deal of one-to-one supervision of skills and little pressure due to the time constraints so inherent in institutional practice. The community midwives rarely experienced shortages of staff. If staff went off sick other staff were asked to volunteer their time off to fill the gap. The majority of midwives did not mind doing this as they received extra pay. A major factor in the student's satisfaction with the community experience was the ability of the midwife to fulfill her role with little restriction from the institution or the medical staff.

4.2 Antenatal Clinics

4.2.1 Description

The hospital antenatal clinics were held all day, five days a week. The community midwives started work at eight thirty in the morning, the same time as the antenatal staff, but considerably later than in the rest of the hospital. The time was set to meet the needs of the clientele who found it difficult to arrive any earlier.

The first task of the day was to replenish the clinic rooms with equipment, information booklets and papers required for booking in clients. The majority of rooms also contained computers from which the midwives could obtain laboratory results of tests performed during the client's previous visits. However, I saw little evidence of their use. The midwives felt either that they lacked the expertise to obtain the information or that the information they wanted was not retrievable. Midwives already felt themselves under pressure because of the large numbers of women to be seen and perceived time spent on the computer to be time wasted. As Jo said "It takes me ages to work out what all those things (symbols) mean and when I finally do the information isn't there anyway. It's just a waste of time". (Midwife)

The first hour of each morning and each afternoon was set aside to book in women who had recently been found to be pregnant. These women had been referred either by their G.P. or themselves for hospital care of some form, whether shared with their G.P. or not. They brought with them booking forms which they had completed at home in order to facilitate the process. The forms contained information on their personal history and were very helpful in the booking procedure.

It was the midwife's task to orient the client to the structure of the clinic and the areas they would be visiting, such as the ultrasound department. Family, medical and reproductive histories were obtained with information provided by the client during a 30 minute interview and written on the appropriate documents. Information was provided to the woman on pregnancy benefits, such as free prescriptions, dental care and monetary allowances. Counselling was provided by some midwives if they perceived it to be a requirement. The woman was provided with a document called a birth plan in order that she could specify the type of care she would like during labour and delivery and these choices were sometimes discussed with her. She was also offered the option of going home early after delivery or staying in hospital for five days.

Blood was taken for screening of the woman's health and ability to progress normally with the pregnancy. The woman's height and weight were recorded and her blood pressure and urine were checked. The woman was then asked to get completely undressed in preparation for a physical and pelvic examination by one of the medical staff. Some midwives would examine the woman for progress of the pregnancy prior to the doctor's arrival while others felt that two examinations were too much for the client. The result of this concern for the client left many midwives feeling they were losing their skills in the detection and assessment of early pregnancy.

The majority of midwives prepared their client's records as much as possible prior to calling them in. This was done to reduce the time the client spent in the room. It entailed filling out prescription forms, hospital charts and completing letters to such people as the health visitor notifying her of the pregnancy. After her examination by the doctor the client was sent to the ultrasound department for a scan of her pregnancy. For most women and their partners this was the high point of the day. As one woman said, "It was the first time I felt really pregnant--when I saw the baby".

When all of the new bookings had been completed women who required only routine antenatal checks were seen. This involved the same routine; urine testing, weighing, checking of blood pressure and abdominal assessment of pregnancy. Results from previous blood tests and ultrasound were checked and advice given accordingly. Women with problems that posed a risk to themselves or their pregnancy were seen by the consultant or one of the members of his team. The midwife would have first checked the woman's physical condition. While the doctor did not repeat the urine test or blood pressure he usually repeated the physical assessment of the woman's pregnancy.

At the end of the clinic day, midwives and students were expected to clean up the rooms and get the equipment ready for the next morning. Laboratory reports that had not been affixed to women's charts had to be sorted through and placed on the correct chart. The charts were then taken to the medical records office for storage.

4.2.2 Stressors

The majority of the students experienced stress while working in this environment. Part of the stress was due to the enormous numbers of women who had to be examined each morning and afternoon in the clinic. Many of the women were given times which were impossible for the midwives to adhere to and some women would become very upset. This pressure of time was exacerbated by some midwives who became very irritable if they thought the clinic was falling behind. When this happened the midwives would badger the students to 'hurry' the doctors who created a lot of the pressure by slowing down the clinic when they re-examined all of the women.

The students also experienced conflict between the educational values they had been taught and the values expressed in the clinical area. The midwifery teachers had expressed the need for individualistic and holisitic care for all women. This type of approach to care was one which required time, a commodity in short supply as far as the clinic staff were concerned. When a couple of students did attempt to provide this kind of care the midwives applied pressure to ensure their compliance with the time restraints. This was achieved through the constant interruption of the students when they were with women with comments such as "haven't you finished yet. There are others waiting".

4.3 Postnatal Wards.

4.3.1 Description

Staff arrived on the wards at seven fifteen in the morning to receive the report from the night staff. This tended to be quite a long, drawn-out affair often taking up the first hour of the morning shift. The ward staff would then be assigned by the midwife in charge to care for a specific number of the women in the ward. Usually the assignment would be to a small unit consisting of six clients if all the beds were full.

After the women had their breakfast, the midwives would check on their physical condition and that of their babies. They would then assist the women with feeding their babies, bathing them and any other tasks requested by the mothers. Often the doctors would appear to do their medical rounds of the women at this time and one midwife would be assigned to accompany them. The women's progress would be discussed and their discharges planned. During these rounds it was quite common for the doctors discussing the women not to request any information from the midwife. The midwife appeared to be there to pass charts and write down notes on what the doctors had requested.

A large part of the midwife's day was taken up by admissions and discharges. Admissions would come from the labour ward and as such could not be planned for in advance. They often came in twos and threes and seemed to be subject to Murphy's Law. They always arrived at the worst possible time for the ward staff, during staff changeover or when there was chaos on the wards from other causes. Often the delivery suite would telephone down to request a bed when there was not one vacant. Although there might be several women on the ward awaiting discharge, their leaving was often subject to the vagaries of their partner's work and available transport. When the women finally left the staff would rush around to clean and make up the beds and prepare the room for a woman who may have been waiting for over an hour in the labour ward.

Admissions and discharges involved a great many administrative tasks which included the use of the computer. On some wards there were ward clerks who would attend to the administrative details but they usually only worked during the day. Prior to their discharge all women received a talk on topics such as, care of the infant at home, how to get in touch with the community midwife if she failed to call and how to contact the health visitor. Feeding practices were reviewed and advice provided on family planning. The

content and format of these 'talks' by the midwives was not something to which I had access because of their personal nature. One woman in the community when asked by the midwife if she had received advice on family planning described it in the following way, "Oh yes, they essentially threw some durex (condom) at me for now and that was it".

Any drugs required by the women upon discharge had to be obtained from the hospital pharmacy. Appointments to return to the hospital had to be made and given to those women who had been the recipients of medical interventions prior to or during the delivery of the infant. Women who had a normal delivery were expected to return to their G. P's for their six week post natal check. Staff were expected to personally conduct all newly discharged women and their babies off the premises. Again this often occurred at the busiest times and students were often used for this task.

4.3.2 Stressors

The character of the work on the wards engendered little student stress. Occasionally when the ward was busy and short staffed there was some degree of stress partly as a result of the workload and partly as a result of the responsibility which fell on the students. However, for most students this was a similar kind of environment to that in which they had experienced in their general training. They were expected to examine women and their babies, assess their physical condition (temperature, pulse, respirations and blood pressure), provide bedbaths for women who had recently had surgery and make the beds. The majority of these tasks the students had performed many times as nurses. Initial stress was present because of the newness of the environment but once the students understood the ward routine and became known to the staff there was rarely a problem.

4.4 Antenatal Ward

4.4.1 Description

The staff began work the same time as on the other wards and their day began the same way. The report was received from the night staff but because it did not include the condition of babies it tended to be considerably shorter than on the postnatal wards. The type of clientele on this ward were women who had personal health problems which were affecting them or the health of their unborn child. Some women were there because the growth and development of their babies were compromised, with no obvious cause. As can be imagined, these women were very anxious about their pregnancy and asked many questions when the opportunity arose.

The women were admitted from home, doctors' offices, antenatal clinics or by referral from the community midwives. Some were admitted in preterm labour as early as 22 weeks of gestation while others were admitted closer to term with growth retardation of the fetus or problems with hypertension or diabetes. Because of the abnormal aspect of pregnancy on this ward it was rare for students to be assigned here until their senior period of training.

After breakfast the women were placed on electronic monitors and their physical status was checked. Those who were close to term and due for a caesarean section would be prepared physically, documents signed and the woman taken to the delivery suite. Those who were to be induced would also receive the appropriate intervention after which they would be monitored for progress and problems. Ward rounds by the doctors would take place after breakfast but would be a lengthier procedure than those on the postpartum wards. Fetal heart tracings would be examined and discussed and a plan of action formulated with the client. For those women whose condition had responded positively to hospitalisation, there was the opportunity of going home until labour commenced.

Occasionally, if all the rooms in the delivery suite were in use, women in early labour would be admitted to the ward for monitoring until a bed became available. Many of the tasks the midwives had performed in the morning would be repeated in the afternoon.

4.4.2 Stressors

Students appeared to experience little stress on this ward. This was due in part to the fact that it was rarely as busy or as chaotic as the postnatal wards. There was not the same number of admissions and discharges and there were no babies to assess and provide care for in feeding and bathing. In addition, because these women had health problems which posed a risk to the fetus there was not the expectation that the student was experienced in caring for them. As a result the students were usually provided with a better orientation and supervision of their skills than was provided by staff elsewhere in the hospital.

4.5 The Labour Ward

4 5.1 Description

On the labour ward midwives were assigned to women in labour after receiving a report on them from the midwives on the previous shift. The number of women to which a

midwife was assigned was dependent upon the number of women in the unit at a specific time and the number of staff. It was not unusual to have between ten and twelve women requiring care with the usual complement of trained staff at approximately six which often included the midwifery sisters. As a result, it was quite common for a midwife to be caring for two women in labour, in different rooms, at the same time.

Care of such women required the monitoring of the fetus either by technological means such as the cardiotocograph or by non-technological methods such as the use of the fetal stethoscope. The use of technology was the prevalent method for all women regardless of whether they were experiencing problems or not. The women were also monitored for progress of the labour and their own health. Other aspects of care, such as the need for pain relief, were also monitored. A fair amount of documentation was required for all of the care that the women received. When the woman was deemed to be close to delivery the midwife prepared the woman and the room for the delivery procedure and obtained the assistance of another midwife to care for the baby after birth.

After the delivery of the infant and the placenta the woman would be assessed in case she had a perineal tear and required sutures. If so, a fresh tray was prepared and a doctor called in to perform the procedure and the midwife assisted. The woman was then cleaned up and given her baby to nurse while the midwife made her and her partner a drink. The midwife examined the placenta for any abnormality, weighed it and placed it in the required receptacle. The baby was weighed, measured and examined. Name tags were placed on him/her and the necessary documentation completed. This involved filling out a record on the length of each stage of labour and a description of the birth and the baby. A notification form on the baby's birth was also completed at this time to be forwarded to the medical officer of health. An injection of vitamin K was given to the baby at birth as a preventative measure against haemorrhage.The delivery of a baby and thus the tasks outlined above required the assistance of two midwives or a midwife and a student.

Once the documentation had been completed the midwife had to take the client's chart and write out the details once again in the birth register. The same details had to be entered into the computer and the woman was then discharged to the postnatal ward. After a sponge bath the woman was taken down to the ward with her baby where she would remain until discharged home. The midwife from the labour ward provided a verbal report for the midwife on the ward who then examined the woman and her baby after placing them in a room.

If a caesarean section was required more preparation of the woman and the room would be needed. If the woman had required a general anaesthetic she would be kept on the labour ward for approximately two hours after the delivery for observation of her condition prior to her discharge to the ward.

4.5.2 Stressors

Students found the labour ward very stressful for a variety of reasons. The labour ward staff, like the staff in the clinic, were not welcoming to new personnel. Additional stresses were created when students were left by themselves in rooms with labouring women, a situation for which they felt ill-prepared. Another problem was that that the labour ward was an area where quite complex skills, such as a vaginal examinations, came under the scrutiny of midwives who were required to sign a form stating that they had assessed such skills.

Students often had high expectations of their own performance in complex skill areas and when these expectations were not borne out they felt very stressed. The staff on the labour ward also appeared to have high expectations of students in that they expected them to care for women when they had only a minimum of training and supervision. Many students were constantly stressed from a fear of not being able to cope if something went wrong.

4.6 Special Care Baby Unit.

4.6.1 Description

This unit provided care for babies who were traumatised at birth, born several weeks before they were due or had been born with some defect that threatened their survival. The majority of the staff who worked there were registered general nurses and not midwives. Many of the staff had obtained additional training in the care of these babies on a course referred to as ENB 405. Training for this course was ongoing on the unit as each new course commenced as soon as the previous one had finished.

Care on the unit involved a great deal of technology, such as the use of intravenous pumps to regulate the very small amounts of fluid required by these infants. Several respirators were usually in use along with positive pressure units and apnoea monitors. There was a great deal of noise in the units as a reult of the technology. Most of the equipment had alarms which sounded when fluid levels were low, babies stopped breathing or when

oxygen concentrations needed adjusting. There was additional noise from infants being suctioned or incubator alarms going off because they required heat adjustment. In addition human noises were created by the doctors on medical rounds, the discussion of nursing reports and visits from parents.

4.6.2 Stressors

The unit was very small and became hopelessly crowded when paediatric rounds commenced or when babies deteriorated or were admitted from the labour ward in poor condition. Parents were able to visit at any time and visits from the infant's siblings were encouraged. Parents had to ring the door bell on entry and this noise added to the general confusion. Student midwives usually came to the unit in their senior period and without prior exposure to this type of care. Many of them felt stressed when presented with the technology, the size and the illness of the babies. This was particularly evident when the unit was busy with the admission of sick new babies and no one had the time to spend with the students.

In summary, those areas that were identified as creating the most stress were the labour ward and special care baby unit, mainly as a result of the technology and a lack of experience to deal with situations when unsupervised. A moderately stressful area was the antenatal clinic partly due to the pressures of time and numbers of women to be seen and partly because of conflict between staff expectations and educational teaching. Additional stress was experienced when students were given minimal orientation and then left alone to cope with the woman's care. This occurred at a time when most women were seeking knowledge of their pregnancy and condition, knowledge that the students felt ill-equipped to provide.

4.7 Specific Areas for Observation

4.7.1 Teaching

Who did or did not actively teach in the clinical area was a major focus for observation. However,. by the nature of my decision to only observe in areas where skills were being practised, it is possible I may have missed out on teaching sessions which were occasionally provided during 'quiet times' on the units. Teaching was an ongoing practice in the community probably because of the proximity of student and midwife when providing care. Such teaching was not always a possibility during busy times on the ward or when shortages in staffing levels were experienced.

4.7.1.1 Community Antenatal Clinics

Midwives were identified as the main teachers of students in the community. Medical staff were rarely encountered in the antenatal clinics in the community and therefore were not available for teaching student midwives. Other health professionals who occasionally contributed were the health visitor, who assisted the midwife with the teaching of parentcraft, and the social worker. The social worker was not present on a regular basis because there were few occasions when she had a client referred by the midwife. It could be said that neither of these personnel contributed on a regular and ongoing basis to midwifery student education.

4.7.1.2 Hospital Antenatal Clinics

In the antenatal clinics teaching was usually at a minimum level (on an information rquired basis), sufficient only for the student to be able to examine clients on her own. Whether the amount of information was sufficient for the student's needs was rarely questioned and there was an implicit assumption that if it was not sufficient then that was because the student was lacking the required intelligence, skills or motivation. So pervasive was this assumption that when asked if they felt confident enough to examine a woman on their own, they usually replied in the affirmative. Some of the students utilised the medical staff for the purpose of checking out their skills. As Marion said,

> "The midwife covering me wasn't checking my palpations on my third and fourth day so I would palpate and wait until the consultant or registrar came in and they would teach me"
> (Week 4, Set C, trained 3 months, antenatal clinic).

Medical staff were always present in the hospital clinics. There were never less than three doctors at each session, with the consultant providing a fourth. Teaching was provided on an individual basis dependent upon how motivated the doctors were. Some were very motivated while others were not. How experienced the doctor was or his/her seniority did not appear to be factors. Students felt they obtained some vicarious knowledge from the doctors just by listening to their conversations with the clients.

The majority of the consultants would teach any student placed in their rooms with them and often provided a teaching session at the end of the clinic if there was time. However, these sessions tended to be geared towards the junior doctors and many students felt the

information provided was too advanced for their understanding. Unfortunately, students rarely informed the consultant of their lack of understanding. Occasionally, the medical consultant would be involved in the teaching sessions at the end of the clinic and tended to be more open to questions from the students. Again however, the students often felt the content to be too advanced for them.

4.7.1.3 Postnatal Wards

The amount of teaching provided on the postnatal wards depended in part on the motivation of the staff, the amount of work to be completed on that shift and the staffing levels. Students would often receive a short orientation to the ward on their first day and be expected to behave as one of the team afterwards taking on their own client care. The amount of orientation varied, with some midwives demonstrating the skills a couple of times and then observing while the student performed them. They would then work alongside the student providing ready access to their expertise and their knowledge.

Other midwives would show the student once and then send her off to care for her own group of patients in a different room from the one in which the midwife practised. Although they were often asked if they felt comfortable with providing care for their own ward of women there was an implicit expectation that the student would acquiesce. There were many variations between these extremes. As Susan said,

> "The first day was great. I was working with Sam and she was really good at teaching. The second day I was just thrown in and told to get on with it. They seemed to forget we were learners".(Week 11, Set D, trained 7 weeks, antenatal clinic.)

One ward provided a notice board on which was written the experiences that were available for student learning. The student would cross off the experiences as she felt she had gained competence in them. The board had been the idea of former students who felt it would increase the probability of teaching on that ward. Whether the board assisted with this or whether the ward sister was more aware of the student needs is difficult to ascertain but there did appear to be an increased prevalence of teaching on that unit as opposed to the other two wards.

There was not a strong medical presence on the postnatal wards. Paediatricians would visit once, unless called in by midwives, to check on newborn babies. This was often

done without the participation of the staff. The obstetrical staff rounds were conducted very quickly because the doctors had other responsibilities in the clinic, the antenatal ward or the labour ward. It was quite clear from observations on the postnatal wards that medical staff found it difficult to identify some of the women they had been asked to discharge. If the ward was busy they would sometimes do the round by themselves. Occasionally the senior students would accompany them but the doctors rarely provided any teaching or new information for them.

4.7.1.4 Antenatal Ward

There appeared to be more teaching on this ward for several reasons. I believe the most important was because the students were usually in their senior period before they were placed here and therefore more confident about making their needs known. There were less sudden fluctuations in work load as the women admitted to the ward were likely to be there for some weeks. In contrast on the postnatal wards the average length of stay was four days.This stability in ward population assisted the midwives in organising their work load to include student teaching. Last, but not least, was the fact that with only one antenatal ward and subsequently only one antenatal placement for the student, the midwives could not assume that the student had previously obtained all the experiences available.

The medical staff spent more time on the antenatal ward and were more inclined to provide teaching on their rounds as a result of the pathology of the pregnant women. This may have been because with the increased length of stay of the women the medical staff had more opportunity to become acquainted with them and their history. Students were often encouraged to go on medical rounds or even to take charge of them because of the teaching content. When medical staff took time to explain things to individual patients, the students obtained even more information from the answers provided to the women or by asking questions themselves. The students appeared to find it more acceptable to ask questions here than on the postnatal wards probably because the expectations with regard to their midwifery knowledge were not as great because of the women's pathology.

4.7.1.5 Labour Ward.

Teaching on the labour ward also varied with work load. During the infrequent quiet periods a midwife was usually delegated to take all the students together as a group and teach them about some aspect of midwifery practice. Because one could not know in advance what working conditions would be present there was rarely any preparation made

for these teaching sessions and they were often conducted from the midwife's memory. No concession was made for the student's level of understanding which meant that many of the students found such sessions to be of little benefit.

During the busy periods students were usually provided with just enough information for them to provide care for the women in labour. Because no explanation or rationale was given to the students, they often became stressed when the outcome did not follow the course prescribed by the midwife.

> Mabel "They don't really tell you what is happening, if they did I could get more from it." (Week 21, Set D, trained 4 months)

Medical staff were very much in evidence on the delivery suite, doing rounds a couple of times a day and visiting all of the women whehter or not their labours were progressing normally. The obstetrical staff and the anaesthetist provided a 24 hour cover on the unit and so were always in evidence. The anaesthetist was usually the busier of the two, providing women with pain relief through the insertion of epidural anaesthesia. On the few occasions when the obstetrical staff were not required they often became bored and would start to check all the women more frequently, even those making normal progress. This behaviour often infuriated the midwives who perceived it as medical interference and it was particularly in evidence when students provided the woman's care. Despite the boredom of their routine the medical staff did not perceive this as time they could spend teaching students.

4.7.1.6 Special Care Baby Unit.

As also mentioned earlier, there were several students already on this unit training in neonatal intensive care. The majority of the staff were mentors for these students which meant that there were few staff available to train the student midwives. If the unit was not too busy the staff were careful to provide the midwifery students with a good orientation as they recognised that the environment could be very threatening. If the unit was busy the midwifery students were often left to manage as best they could. However, the staff did appear to recognise their role as teachers partly due, I believe, to the fact that they always had some students in training. As a result the student midwives usually received whatever training was available.

There was medical coverage 24 hours a day on the unit so the medical staff were very much in evidence. Unfortunately, due to the paucity of observations made on the unit I cannot comment on their attitude to teaching. The few observations I did make revealed that the medical staff demonstrated a friendly and approachable style of interaction with the nursing staff but made little attempt to teach students, responding only if asked a question. As there were teaching rounds open to all on a regular basis it may be that these were viewed as the main vehicle for educating the staff.

4.7.2 What Was Taught

The majority of teaching carried out by midwives and medical staff focused on specific tasks, such as abdominal palpations or vaginal examinations. Areas such as decision-making during labour or problem-solving in the clinical area were rarely taught. At times there appeared almost to be a conspiracy to keep the student ignorant as to how or why decisions were made. I am not suggesting that it was a conscious decision to keep students in the dark but that somehow the students were equated with the clients on a 'need to know' basis, or in this case, a 'need not to know'. This attitude appeared to be more prevalent on the labour ward than in such places as the clinic where problem-solving was taught by some midwives for specific situations. In the delivery suite the doctors tended to focus their teaching on limited areas, such as the effects of epidural anaesthesia, how to suture an episiotomy or the need for medical intervention. Decision-making and rationale for when to apply forceps, perform a cesarean section or induce a pregnancy were rarely discussed in front of the student or the client.

Midwives tended to have certain tasks that they routinely taught to students and these were usually associated with the care the student was expected to provide on the unit. Whether these were tasks they themselves had been taught as students is interesting to reflect on, but would require another study. On the labour ward it was skills such as abdominal palpation, vaginal examination, the electronic monitoring of labour and the delivery of babies that received the main emphasis. On the antenatal ward the major focus was electronic monitoring of problem pregnancies, while in the clinic it was abdominal palpations, new bookings and the timing of client visits and diagnostic tests.

On the postpartum ward the focus for teaching was the examination and admission of mother and infant and routine postpartum care. Breast feeding was a skill all students wished to be taught but was not an area in which many midwives appeared to feel comfortable. The tendency was to send the student off to try themselves and return if they

needed help. Other skills which received some attention from some of the midwives were those associated with the client's discharge, such as family planning.

On the special care baby unit the students learnt some of the technology associated with the care of the intermediate babies, such as the use of pumps, nutritional requirements of preterm infants, the use of apnoea monitors and the care of babies in incubators. The intermediate babies were ones who were either not sick enough to be on respirators or had been weaned off them and were being prepared for transfer to the wards. Students were not expected to care for the really small babies or those who were seriously ill, such as those on respirators. The teaching on this unit tended to be geared more to what the staff felt the student should learn from this experience rather than just to those skills associated with the care of the infant.

4.7.3 How Students Were Taught

Demonstration appeared to be the favourite mode of teaching although some midwives used visual imagery, such as clocks for identifying positions or bananas to represent the birth canal. Diagrams were used by a few midwives to identify parts of the anatomy for students who had some difficulty with visual imagery. Occasionally the medical staff used visual imagery or diagrams but were more likely to provide information through discussion and feedback.

Role modeling was used by most midwives particularly those in the community.This method was utilised mainly to demonstrate interpersonal skills, such as counselling or when attempting to build a rapport with a new client. Feedback was not a method used as often as the students would have liked. Some midwives gave feedback on skills performed by the student while others did not. Even when feedback was provided it was rarely in sufficient detail to be of use to the student. Feedback was provided by some of the medical staff when observing students performing skills but again it was often not specific enough to be of use.

Teaching in isolation from the client was the method used most frequently during the 'quiet times'. The midwife and students would usually find themselves a quiet place where the midwife would offer to respond to any questions the students had. Usually the midwife borrowed a textbook from the ward for a ready reference in case of dispute over the appropriate response to questions asked.

4.7.4 Supervision and Evaluation of Students

The word 'supervision' was used frequently when student education was broached with the midwives. However, it appeared to have a variety of definitions dependent upon the midwife and the clinical environment. For some midwives supervision appeared to mean the close monitoring of students in the clinical area. Still others felt they were supervising if the student was working in a ward separate from themselves but they were available for the student if she needed anything.

In the antenatal clinic supervision appeared to mean the midwife would spend the first day with the student to demonstrate care, observe the student while she attempted to replicate the midwife's skill and then give feedback on her performance. The second day the student was on her own covering clients in two rooms while the midwife covered two rooms further down the corridor, The student was usually told to 'give me a call if you need anything'. Students in their junior period found this very threatening because they were so unsure of their skills and so inexperienced that they were concerned about doing damage to the client.

On all of the wards a somewhat similar situation prevailed. Students were shown certain skills, in some situations were observed on how they performed the skills and then they were expected to work alone. Nominal supervision was provided by the midwife in the next room. Some midwives were very conscientious about providing students with the appropriate feedback while others did not even stay to watch them perform their skills.

On the labour ward students were supervised much more carefully and some form of limited evaluation was usually provided. This may have been because this was an area where, technically, they could do more damage to the mother and child which would then be the responsibility of the midwife. It may also have been due to the fact that midwives appeared to be more motivated in this area as a result of the challenges it provided. Whatever the reason the supervision and evaluation were better on this unit than on any other unit on this site.

Evaluation was another word with a number of definitions. For some midwives it meant the assessment of a specific skill at the time that it was being performed and the provision of feedback. For others it meant assessment with little or no feedback while others saw the need for evaluation only when the student was completing her clinical rotation on the ward. The latter type of evaluation was one required by the school and had to be formally

documented. The most frequent type of evaluation was for the student to be told her examination or her skill was 'alright' but she would be left unclear as to what was or was not 'alright'. Students constantly complained about this approach as they felt it taught them nothing.

Midwives who appeared motivated to teach students provided them with more learning opportunities, better supervision and more appropriate feedback on their performance than midwives who appeared indifferent to teaching. Some midwives articulated a need for all midwives to teach students but devised a variety of strategies to avoid a teaching situation.

The nurses in the special care baby unit were also very aware of their role as teachers and provided learning opportunities and supervision as much as was possible under the circumstances. Those nurses who were not motivated to teach were known to the unit sister and not given any responsibilities with students. As such, the students were generally very positive about their experiences in this area.

Students were very specific about the areas in which they received the most teaching but these areas did change depending on staffing allocations. Two groups of students had complained bitterly about the antenatal clinics while a later group found it provided them with good experiences. One group of students complained about the 'boredom' of the community experience while other groups enjoyed it as they felt it more fully demonstrated the role of the midwife. There were no exceptions among the students in their complaints about the labour ward and the chief complaint identified was being left alone with a woman in labour. Many of the students found that night duty on the labour ward provided a more positive experience.

Summary

The descriptions of the clinical environments and the stressors they created suggested that the labour ward and the special care baby unit were the areas which created the most stress for students for diverse reasons. Both created stress because of the amount of technology in use. Stress on the labour ward was created because of a lack of direct supervision and teaching and because students were often left on their own with women in labour. In the special care baby unit stress was initiated by having to care for the very small, sick babies, the amount of noise and the lack of experience students had in this area.

The teaching, supervision and evaluation of students were dependent upon a variety of factors, such as the staffing levels, the workload of midwives and their motivation to teach. Midwives who were motivated would find the opportunity to teach regardless of the organisational conditions and constraints.

In the next chapter the learning process as it applied to this study site will be discussed. The opportunities provided by the midwives and by the organisation will be identified.

CHAPTER FIVE

THE LEARNING PROCESS

This chapter will identify some of the major learning opportunities provided by midwives to assist students in learning clinical skills. It will also identify situations where learning opportunities were not provided and the student had to use various strategies to obtain them for herself. The learning successes or failures resulting from the opportunities provided and the strategies used, will be discussed in light of the student's perception of the relevancy of the experiences.

Several conditions were identified as creating conflict between students and personnel in the clinical environment. A major source of conflict was the incongruence between student expectations and the expectations of the midwife with regard to what was necessary for the student to know in order to care for her client. For the student, the goals were competence and confidence in the practice of clinical skills. For the midwife, the goal was to ensure that the student had sufficient information to provide safe care for the woman. Of course, the goals did not need to be dichotomous. In achieving her goal of clinical competence the student would be complying with the goal of the midwife in providing safe care. However, the midwife often stopped short of providing the student with the opportunity to obtain competence and confidence. As a result, the midwife's teaching strategies were often aimed at ensuring the student provided safe care but not necessarily competency in skills.

5.0 Learning Opportunities

Boud, Keogh and Walker (1985) remind us that only learners themselves can learn and only if they can reflect on their experiences. The learner determines what she is able to learn but she has limited control of her learning opportunities. In institutional settings, like the hospital, the learning environment is controlled by people with superior status, such as the medical and administrative staff, closely followed by the senior midwives.

Medical and midwifery staff controlled the clinical learning opportunities that were available to the student both indirectly and directly. The medical staff's control was less direct in that it was achieved through medical interventions with clients for whom the

midwife or the student was providing the care. Medical control was also achieved through hospital policies which could restrict the decision-making available to the midwife and thus the learning opportunities of the students.

The midwives' control was direct as a result of the expectation that they would provide orientation and supervision of the students' practice. Control was also achieved because the midwives provided the major part of the care for the clients and therefore, the majority of the learning opportunities for the students. These opportunities ranged from simple observation of client care to a practical demonstration of skills which students were then expected to replicate.

Some of the more senior students felt a need to participate in negotiations to increase their learning opportunities which they felt were too limited. Such negotiations depended partly on the students' stage of professional development within the midwifery programme and partly on their personality. The end result was often the need to develop self-learning strategies to compensate for the lack of teaching provided by the midwives.

5.0.1 Observation Only

Observation was the first learning opportunity provided by midwives when faced with the responsibility of a new student. As a learning tool, observation was a skill well developed by most students as a result of their nursing training. It is a skill required by a nurse in order that she may be able to identify any changes in her patient's condition which may or may not be a cause for concern and action. However, for the performance of more complex skills it would appear that other input, such as practice with the appropriate feedback from an instructor, was required in order that the skill could become part of the student's repertoire of behaviour. One of the managers appeared to think that observation by itself could be sufficient.

> Manager "I think the students best learn by watching. Obviously, some may be done as conscious teaching by the midwife to the student, but I think, certainly when I think of my own learning experience, I learnt a great deal from watching--um--the defined skills but also the attitudes". (Week 9 interview)

This statement came from a manager who had trained many years before when technology was far less evident and midwifery care more basic. It is possible that during her training

days observation was sufficient to obtain some of the skills required by a midwife. However today, with midwifery research, more complex technology, survival of small birthweight babies and the possibility of reproduction in previously infertile couples, the skills to be learnt are more complex than those required twenty five years ago.

For many people, to learn from observation requires an auditory input, such as an explanation of the process involved in performing a skill. Observation by itself does not appear to be sufficient to provide a cognitive framework on which students can place new information, unless that visual information is very simplistic. Observation can be very misleading if the observer misses a step in the performance of the skill. It would appear from my observations that an explanation was necessary for the student to be able to place the information in the correct sequence in her memory for appropriate recall. The explanation does not necessarily have to be the correct one in order for it to be recalled by the student.

> Linda "Yes, you often find you have been doing things for months. Suddenly, you find you have been doing it wrong or else there's something you have been missing and when they tell you you realise that now it is complete. You often get conflicting advice". (Week 11, Set A, trained 17 months, interview)

While Linda was able to identify that everything was not as it should be with the way she was functioning, it was not until she was provided with the correct information that she was able to identify the problem with her practice. However, the misinformation that she had received earlier, whether it was observational or auditory, did not prevent her from continuing to practise the skill albeit in an incomplete or inappropriate form.

Auditory input was often the vital ingredient missing from the observational period in the first few days of the student's training. Midwives appeared to want to get on with their work rather than to stop and explain their performance to the students. They seemed to be under the impression that observation was sufficient in the early days for the student to pick up information on the midwife's role. It may be that to teach a new student required more time and effort than they had been prepared for or felt able to provide. Observation did seem to be sufficient for many junior students in learning the simple tasks such as bathing a baby, and for an understanding of the routine of the midwife's work, but not for more complex skills such as assessing the progress of a woman's pregnancy. It is also

possible that observation was sufficient for students just beginning their training in order that they did not suffer from information overload.

Many students also appeared to believe also that observation was sufficient and seemed quite surprised that, after a few days of observation, they were unable to replicate the midwife's performance efficiently. Sarah (Set D, trained 3 weeks) provided an example of such a situation. She was standing in the room with a woman who was being prepared for a caesarean section. The midwife went over to the resuscitaire to check it in preparation for the infant. Sarah went over and watched her while the midwife continued with the check without saying anything. Later in the day, when Sarah was asked by the sister to check over the resuscitaire, on the assumption that she had learned sufficiently from the previous check, she was surprised not to feel confident about doing the check alone. It is probable she felt unable to say this to the sister because she was so new in her training.

Fortunately for the students, observation as a teaching strategy did not continue for long. This was due, in part, to the midwives wanting to move the students into more independent functioning and, in part, to the students wanting to be more involved. There were numerous examples of such observational experiences for students in the early periods of their training, becoming much less common in the later stages and then occurring only if the midwife was under pressure due to a deterioration in her client's well-being.

Observation as an early teaching strategy was a common experience for the first two groups of students observed, both of which were placed in the clinic and on the wards at commencement of their training. A change of strategy was made by the education department for later groups, in order to facilitate a better alignment of the practice component with the theory presentation by the school. Thus, the third and subsequent groups of students were placed with community midwives for the first six weeks of their training, resulting in one-to-one teaching and much less evidence of observation, except for the first few days.

Many of the midwives were aware that the students required more observation or demonstrations of skills than they actually received.

> Midwife "I think they could do with more demonstrations. Um, I think they're expected to take over a lot of care very early on, as soon as they're feeling competent and really as soon as we feel happy". (postnatal ward)

The implication here is that 'we are happy sooner than we should be' because of the shortage of staff and the need to use the students for the provision of care. This has also been noted in studies of nursing students. Jacka and Lewin (1987) found that nursing students in their study worked infrequently with trained staff and were seldom supervised in any performance. They also noted that the ward sisters saw themselves as closely involved in the teaching and supervision of students but that this perception was incongruent with that of the students.

In a manner comparable to the findings above, there were a few midwives in this study who felt the students had better teaching and supervision than the students themselves thought they had,

> "They feel they have a lack of knowledge. We know how much knowledge they have and we know when we need to be following them. But they believe that they are much more left to themselves than they really are". (Midwife, postnatal ward)

The need to use students for service because of the shortage of staff was a fact frequently recognised and referred to by many of the midwives and was the usual reason given for not providing adequate teaching. This rationale was used so frequently that even a few of the students began to accept the shortage of staff as the main cause for the lack of teaching. However, one or two students were able to identify the major problem as the lack of recognition and importance placed by the midwifery hierarchy on the teaching of students.

> Maureen "There's no structured teaching as such.You just get allocated to a midwife and its up to her how much you are taught. You get some midwives who just go and sit in the office and leave you to get on with it. Just come back every four hours. (laughs) And you get some who will stay in the same room with you and go over things". (Week 60, Set C, trained 17 months, interview)

Some midwives and a few of the students felt that one of the reasons midwives were not keen to teach was because of a lack of interest and perseverance by the student.

> Florence "It depends how firmly you ask them (midwives). Yes, I think if you are interested enough then most people are keen enough to answer your questions, but its got to come from the student". (Week 25, Set D, trained 22 weeks, antenatal ward)

After a minimal observation period in the community or on the wards the midwives moved the students onto the stage I refer to as 'show and tell'. An interesting fact to emerge from the data is that very few midwives or students perceived observation alone to be sufficient for teaching skills and yet it continued to be utilised so regularly in the early phases of the student's training.

5.0.2 'Show and Tell'

'Show and tell' was the next step in the provision of student learning opportunities and consisted of the student being shown a skill once or twice and then being expected to perform it with some degree of expertise. 'Show and tell' was an area which could be split into two types of experience, one concerned with direct teaching and one with indirect teaching.

5.0.2.1 Direct 'Show and Tell'

This term has been used to identify a situation where the midwife consciously attempted to provide teaching opportunities and information in order for the student to learn specific skills and routines.

> Lynne "When I first came here was assigned to a nurse who turned out to be my mentor and she showed me around. How much teaching or instruction you get depends on how busy they are. They demonstrated a postnatal check on the patient and baby 6 or 7 times that morning. They weren't busy at all then, I have to admit". (Week 23, Set E, trained 5 weeks, postnatal ward)

There was a fairly wide range to the number of times students were provided with demonstrations. 'Show and tell' opportunities were often limited because of the shortage of staff and sometimes by the midwives' lack of motivation in teaching the student. This

latter situation was observed in the occasional 'quiet period' when the midwife frequently failed to take the opportunity to teach the student but instead sat and chatted to her colleagues. Some midwives were very conscientious in demonstrating skills and supervising the student's performance of skills until the student felt confident to continue on her own. However, there were quite a few who believed in a minimal number of demonstrations and did not always wait to assess the student's performance. There were numerous complaints from students about this style of teaching usually because they felt they were not provided with enough demonstrations or supervised practice. Peggy described a typical situation,

> Peggy "Its ages since I was supervised. Usually get supervised for first one or two (antenatal assessments) and then you're on your own". (Week 5, Set A, trained 15 months, antenatal clinic)

Peggy was describing conditions in the antenatal clinic but such situations were common in all teaching environments except in the community. While many students blamed the clinical environment for the lack of learning opportunities, one student identified the midwifery school as partly to blame. This student, who had recently commenced the midwifery programme, felt the problem was due to the school not providing sufficient support and placing too much reliance on mentorship.

> Roberta "They left us — left me to get on with it, and I don't think the mentorship programme is working too well". (Week 19, Set E, trained 3 weeks, labour ward)

I think it is clear from this conversation that this student felt abandoned by the educators. The school had initiated the mentorship programme in the hope of reducing some of the practice problems students encountered when they first entered the clinical area but, as indicated earlier, it had not been successful. Gott (1983) also found nursing students ill prepared by the educators in clinical nursing skills. She felt that it was unfair to include skills in the curriculum without ensuring that students developed proficiency before they were required to perform such skills on the ward. She suggested that this type of situation created increased unnecessary stress in a student who was already anxious. It was quite clear from my study that increased anxiety was the result of inadequate learning opportunities and poor preparation in skills prior to entering the clinical area.

For some midwives, teaching students meant orienting them to the routines of the ward in order that they could be more efficient in the provision of service. The emphasis in such situations tended to be placed on the service needs of the ward rather than on the educational objectives of the student. One midwife when asked about the teaching of students on her ward gave the following response,

> Midwife "If they are taken on properly by a midwife who has been on the ward for quite some time then they are given a proper orientation, the best routine of the ward. They are working attached to their mentor for at least a week, then they seem to catch up with the routine of the ward and the management of the mothers. They have no problems when they come for a second allocation". (Postnatal ward)

It is interesting to note the idea of the necessity of an orientation to the service aspect implicit in the midwife's conversation. The students, if properly trained in service, were expected not to present any problems or need supervision when they returned to the ward for their second allocation.

Another point to note is the use of the word 'management' in the anecdote. Kirkham (1987) noted in her study an attempt by midwives in the labour ward to control or manage their clients. This control was evident in a few midwives on the labour ward at the study site and such 'management' was often extended to the clients on the wards and to the students.

One midwife freely admitted the service orientation when questioned about student teaching,

> "I think we are happy with the student's work much earlier than we want to be and it's because of the pressure of staff". (staff shortages)

Not every midwife was as honest about the service orientation although many did blame staff shortages and lack of time for the dearth of teaching on the wards. Marion supported this rationale in her statement,

> "Obviously shortage of staff and availability of staff to teach is the main reason that we don't get much teaching. They aren't always available to supervise you--". (Week 53, Set C, trained 16 months, interview)

However, Mabel, a more junior student, thought there were probably additional factors but she was not going to commit herself to specific complaints about midwives.

> "We don't get sufficient teaching. No, definitely not. laughter) Whether its midwifery shortage or lack of motivation on the midwives' part or poor management, I don't know". (Week 55, Set D, trained 12 months, interview)

Like many students Mabel used laughter to reduce the negative impact of her complaint. She identified two factors as being implicated in the lack of teaching not wanting to specifically focus on the midwives' lack of motivation as a major cause.

Some clinical areas were clearly more oriented towards teaching than others, just as some midwives demonstrated an interest in their student's achievements. The areas which appeared more oriented towards the provision of opportunities for students to learn were those which identified teaching as a priority and a part of the ward routine. Only two wards, one antenatal and one postnatal, had a structure in place on the ward for teaching students. Staff on each of the two wards had identified skills they expected students to have mastered before they left. These skills were written alongside students' names, on a board placed on the office wall, and students were expected to fill in the skills when they felt confident in their performance. Needless to say these were the wards identified the most frequently as providing the students with appropriate teaching/learning opportunities.

> Marion "I think it depends on the wards, some wards are better than others um-- I think I was lucky. I always asked. Sometimes I think you did it on your own". (Week 53, Set C, trained 16 months interview)

Anxiety often intruded into conversations about learning opportunities. All of the students identified anxiety-provoking situations such as that created on the labour ward by poor supervision, revealing how such anxiety created a stress which was not eliminated with their removal from the area. Revans (1964) has described hospitals as 'institutions cradled

in anxiety'. Students were very prone to anxiety when faced with performing skills for which they had too little preparation. The ward climate had an effect on student learning in that some wards were perceived to be more motivated in preparing and teaching students than others. The labour ward was one area where the students' perception was that teaching was provided only in order that the staff could leave students alone to care for women in labour.

The special care baby unit was an area which was identified as providing appropriate learning opportunities and teaching, although students found it a stressful place to work in because of factors mentioned in Chapter Four. It had a very structured teaching programme of clinical preparation for a nursing course in neonatology. This course ran for six months, twice a year, with the result that there was an expectation of all staff that they would teach students. Although anxious about working in such a stressful environment, few students complained of lack of teaching during their clinical placement.

> Fiona "You'd come in (S.C.B.U.) and think, "I hope I haven't got any sick babies — you know? You feel you should know what to do. You really do. You just think, 'Oh God'. The sight of the incubator — you've never seen one before. But they're very good at teaching here, everyone is". (Week 28, Set C, trained 9 months)

5.0.2.2 Indirect 'Show and Tell'

This provided a fair amount of student learning. This type of learning opportunity has been designated as indirect because the opportunities were not provided by midwives and doctors in a direct fashion but through their interactions with the client and each other. Indirect refers to the fact that the midwife's objective in this interaction was to provide information to the client or to exchange information with the doctor but not to teach the student.

This form of self learning developed in students who were able to recognise the value of listening in on interactions between midwives and their clients, midwives and the medical staff and the medical staff and their clients. I have identified this type of learning as indirect because not all students were able to use it to advantage.

> Marion "I know more today---like the co-op card."
> M.C. "How did you find out?"
> Marion "I was in with the doctor and he was explaining it to the patient". (Week 7, Set C, trained 4 months, antenatal clinic)

Most students were fairly quick to identify this as a method of learning new information as Linda pointed out,

> "You would be stupid not to listen to what the midwives or the doctors said to the woman----it gives you an idea what is going on". (Week 54, Set A, qualified 8 months, interview)

The fact that some students felt the need to listen just to find out what was 'going on' gives an indication of the lack of communication some midwives demonstrated with their students. One or two midwives were seen to be 'guarding' information by leaving the room to discuss their clients with the senior midwife or the doctor and telling the student to 'stay and look after' the client. In one situation a midwife was observed to be huddled in a corner with a doctor conducting the conversation in a voice too low for the student to hear. In a similar case, a student requested feedback from such a conversation and was fobbed off with a terse reply which did not begin to provide the gist of the conversation. Bronwen, who attempted to listen in on the conversation concerning the woman for whom she had been caring for the last six hours, was foiled in her attempt. As she approached the midwife and the doctor, the midwife turned her back and leaned over the cupboard against the wall to converse with the doctor allowing Bronwen no access to the conversation.

The women who attended the clinics were a serendipitous source of information for the students as they discussed their interactions with their doctors and other midwives. Many of the women, a large majority of whom were from the middle classes, were very articulate about their needs. In attempting to obtain answers for these women from midwives and doctors the students were able to learn not only about symptoms which upset the women but also some of the recommended solutions. With a clientele less educated and articulate it is possible that this type of information would not have been as forthcoming.

5.0.3 Tutorial Teaching

Tutorial staff were not much in evidence in the clinical area. As Janet noted there was an unfulfilled need for their expertise.

> Janet "In general there is a need for more clinical tutoring. I had no clinical tutor come up while I was here (labour ward) and I'm finished up here at the end of the week. Its the end of my labour ward experience. I'm not coming back. Been up here — let me see now — 6 weeks plus 2 weeks of nights — about 14 weeks altogether. Tutors said they would hopefully get up as much as possible but I've seen no one". (Week 9, Set B, trained 10 months)

Although the midwifery teachers were rarely in evidence, both the service side and the students did expect to receive more input from them than was forthcoming. Students and midwives perceived a more active role for the midwifery tutors in order to ensure some continuity of teaching or even the provision of teaching for the students in clinical areas where it was not provided.

> Linda " We need more continuity. Need a midwife to teach you properly and then let you do them yourself. I think a big help would be to have the tutors on the ward. The mentors are a great idea although I found out the other day that Joyce was my mentor. When I told her she said 'Really?' But tutors should do more clinical teaching on the ward". (Week 8, Set A, trained 17 months, labour ward)

The implication from this conversation was that the midwifery teachers should be in the clinical area in order to supplement the inadequate teaching. There was also a recognition that teaching could be done better if performed by people who were more aware of student needs. The teachers recognised the lack of teaching but felt it was up to the service side to sort it out. The service side felt it was a problem for the education department and clearly expected it to be resolved by the advent of the teachers in the clinical area.

> Sister "I think clinical teachers are probably useful on the wards because sometimes, obviously the midwives are very busy and um and probably they're not taught the proper way (students), they just pick it up by maybe seeing it and not actually being taught it properly". (Week 12, postnatal ward)

Here the sister not only acknowledged that observation, while evident as a teaching tool, was not always appropriate by itself but also that midwifery teachers should be available to fill in the gaps when midwives were unable to teach students. The term 'clinical teachers' was not used appropriately in this conversation by the sister because clinical teachers did not exist at this time. Later in the fieldwork period one midwifery teacher was employed to work part time in the education department and part timeon the wards to increase the amount of clinical teaching provided. All midwifery teachers were expected to provide clinical teaching as they felt it was required by their students, in addition to their educational duties. Other midwives had more professional reasons for wanting teachers in the clinical area. One felt that the midwifery teachers would help the staff to keep up-to-date by making them more aware of changes in clinical practice and recent publications in research.

> Midwife "I think sometimes its nice for us to know what sort of ---- the up-to-date teaching--.Take something like breastfeeding, because when we were taught it was maybe different. Like now, you know, they were supposed to empty the whole breast and not just do 10 minutes there, yeah? Cause even like palpating the uterus, you know, measuring with tapes and things like that. I think -- because you obviously want to teach them the way they're taught now so they're not confused really". (Week 19, postnatal ward)

A second midwife felt that the education department was not in touch with the reality of the clinical environment. The reality for her was that the medical staff's requirements had to be taken into consideration and, when students were not provided with this information they became confused.

> "You know, different cases and different doctors. Different consultants have different ways of doing things and I think certainly the students are taught the way in school and um they're all different They all aim at the same thing but its just the way they do it. It's different so I think they do get a bit confused". (Week 19, antenatal clinic)

The interesting item here is that the education department was well aware of some midwives' adherence to the routines of the medical staff which they identified as the medicalisation of midwifery. Students were taught by the midwifery teachers about the medicalisation but not in a positive way. It was taught in the fashion of 'this is not what we want to see you doing in the clinical area'. I believe it was this stance of the school versus that of the service side which led to some confusion in the students concerning the appropriate way to practise.

Gott (1983) also found that some students felt they were not adequately prepared in practical nursing skills and lacked the interactional skills to respond to their patients' needs. Students in this study complained about the lack of preparation for counselling women, such as those who had abnormal pregnancies. Orton (1983) and Fretwell (1980) suggest that nursing practice should be taught in clinical areas with the expectation that it would be taught by educators. Gott's study supports this idea in that she found that nursing practice taught exclusively in the classroom bore little relationship to nursing practice in the clinical area.

There were some areas of conflict between service and education with regard to midwifery practice but usually it was confined to the few skills that were taught by the tutors. This conversation was recorded after a student had requested the opportunity to do an abdominal palpation on a woman she had seen in the antenatal clinic. The midwife grudgingly agreed that the student could go ahead but then criticised her technique as she palpated the woman.

> Midwife "Well I palpate with both hands---how can you feel if you hold one side ? All you are doing is pushing the baby against your hand". (Week 9)

At no time did this particular midwife appear interested in learning a different technique for assessment nor did she question the student as to why she performed the technique in

that particular way. This was one of those occasions when the student's confidence was adversely affected because of the midwife's desire to demonstrate superiority in the skill of assessment. This particular midwife was observed to be tied into a functional mode of skill performance which did not allow for variations in technique even though the outcome may have been the same. This same type of behaviour was also observed in the labour ward when a few midwives would criticise students who had not organised their delivery trolleys in the way that the midwives felt was appropriate. If the midwives had trained in different hospitals, with different ways of performing tasks, students were usually expected to perform according to the way the midwives had trained. If the student changed her midwife mentor each time she changed shifts, which was not uncommon, she was left feeling very confused.

Vollman (1989) suggested that the primary responsiblity of a clinical instructor in nursing was to facilitate the transfer of learning from the theoretical to the practical with respect to the specified goals and objectives of the course being taught. Students learn how to apply theories of nursing action to real clinical situations, they learn how to learn and also they become socialised into the profession. However, Vollman was recounting the established method of clinical training of student nurses in North America which does not appear to be the same method as that applied in Britain (Jacka and Lewin, 1987; Ogier, 1989).

In the midwifery profession on this site there were no clinical instructors for the midwifery students to ensure the integration of theory and practice. This task appeared to be left to the midwives with little assistance from the education department. If the midwife had not been exposed either to the theories of midwifery action learned by the student or to the content taught she faced some difficulty in the application of such content to clinical practice. When the teaching staff were present as rarely as observed during this study, then the midwives received little asistance either with their understanding of the student's programme or how they learned. Midwives were often not aware that students had not been taught theory prior to working in some clinical areas until after they had spent their learning period in that placement.

Alexander (1982) found that student nurses considered their programme lacked integration when their practice was not realisitically depicted in classroom teaching, when theory was not followed by practice, when the clinical staff were unaware of the student's level of training and when there were conflicting values between education and service

staff. Despite the passage of eight years between Alexander's work with nursing students and this study of midwifery students, our findings are very similar

5.0.4 Trial and Error

Vollman (1989:3) defines clinical learning experience as the totality of directed activity in which a student engages with a patient. In 1933 Dewey identified two kinds of experiential processes which he believed led to learning. The first process he referred to as trial and error and the second, as reflective learning. Reflective learning will be dealt with in the next chapter. Dewey suggested that the value of trial and error was limited to the type of problem that needed to be solved as well as the scope of the exploration. The value can also be limited by the fact that the learner may not always be aware of whether the replication of a performance is correct and therefore learning may be inappropriate.

Trial and error appeared to be the main learning opportunity obtained by students in the absence of a structure for clinical learning on the wards and in the clinic. This approach was partly the result of pressure from some of the midwives who believed that you had to 'do' in order to learn. However, the mythology surrounding this belief was that you could 'do' in isolation without the presentation of information, feedback, or time for reflection. In this scenario, the student was encouraged to approach the midwife for assistance only if she ran into a problem. If this happened the midwife would take one of two actions. She would either attempt to resolve the problem and include the student in the solution, teaching her the appropriate course of action, or she would reach a decision on what course of action to take and send the student to perform some other task without including her in the decision-making or the outcome.

There were three different approaches evident under the rubrick of trial and error learning which reflected the amount of input that was provided by the midwives. These approaches were based upon the amount of indirect supervision students received. The first one I have described as 'thrown in' because this was the term used by many of the students.

5.0.4.1 'Thrown In'

In this approach to learning, the student not only did not experience supervised and directed learning activity but was left very much on her own to identify her own learning opportunities. For example, she would arrive on a ward and be told to 'look after room 6'. Room 6 could contain between four and six women with their babies. The student would be provided with the same information which all staff received on the women in their care

and would then be left to provide the care with no further instruction or evaluation of her skills. It was very rare that the report given by the midwife on the women was used for teaching students. The student was usually told that one of the midwives could be called from another ward if she needed help.

A similar situation was documented in the labour ward. Here the student was told her supervising midwife was working in the next room and could be called if she needed help. The student was then left alone with a woman in labour and only provided with the information on her condition.

> Susan "I was left on my own because they were really busy — I was a bit worried because there were decelerations without contractions". (Week 7, Set D, trained 16 days, labour ward)

Susan had been placed on the labour ward for two weeks to provide her with an orientation prior to being allocated for her six weeks in the community. Linda, a more senior student, felt that on looking back there had been insufficient teaching of skills in the early period of her training for the type of performance that was expected of her in the clinical area.

> Linda "You need more supervision and teaching of skills in the early days. They should sit down at the begining and say 'this is what we do' — never get an introduction or anything. You are suddenly in the middle of it and no one tells you what to do, just left to get on with it". (Week 8, Set A, trained 16 months, labour ward)

Occasionally the midwife would brief the student on what was expected to happen to the woman in her care and what symptoms to check. However, if the student was very junior, she was often unable to comprehend what the midwife had said. The fact that the midwife said it implied to the student that it was something she was expected to know. As a result, she often felt unable to tell the midwife that she did not understand what was required of her. The outcome was a very anxious student who spent her entire shift hoping that nothing would go wrong and fearful of what would be expected of her the following day. This type of stress was also seen occasionally in the more senior students when they felt ill-prepared for the responsibility they had. The staff usually failed to recognise the

student's stress because as far as they were concerned the responsibility was with the supervising midwife.

5.0.4.2 Preview

The second approach was the one most commonly used for students in the early stages of training. In this approach a skill would be demonstrated once to a student with the expectation that she would continue with the practise on her own. It was a similar approach to that described in 'show and tell' except that in this situation the number of times the student was shown was usually limited to one. One example of this kind of approach came from a midwife who seemed to feel ambiguous about how much the students needed 'looking after'.

> "The students are on their own--we don't take them by the hand--shortage of staff and everything. We show them everything first--the checks, the baby exams and then they do it".(Week 19, postnatal ward)

This approach was also identified by a student complaining about the conditions for students on the ward.

> Jackie "We were shown when they came from the labour ward, how to receive them---once.They tend to say 'best way to do it is by yourself--go and do it and if you have any problems---?" (Week 64, Set E, trained 10 months, interview)

For many of the students this was the most consistent strategy used in the clinical area and all of the students experienced it at some stage in their training. As Violet said,

> "I was shown an admission the first time and then I did the second one. My mentor wasn't with me the whole time but she checked afterwards that I had put everything in the right place".(Week 5, Set C, trained 3 months, antenatal clinic)

Students did not always recognise that this type of 'checking up' was not always for their benefit and did not teach them a great deal, except about documentation. 'Checking up' was often done by the midwife to ensure that she did not get into trouble because of the student's documentation. This type of behaviour certainly did not enhance students' clinical

skills although it may have enhanced their knowledge of the legal requirements for practice.

Some students received even less instruction than that described by Violet in the anecdote above. When Myrtle asked the ward sister about doing a C.T.G (cardiotocograph) the sister told her to 'go and do it and then I will come and check it'. Myrtle had never done one before outside the labour ward. This was her first experience on the antenatal ward and she was feeling very uncertain of her skills. She felt compelled to ask a more senior student for assistance. The only response she received from her request was the information that she should not perform a C.T.G without first palpating the woman. As Myrtle felt uncertain about her palpations, this information proved to be of little use to her. She solved her dilemma by taking the women's temperatures until such time as she could find someone to assist her with applying the C.T.G.

A common complaint of students was that if the midwife was asked to come in because of a difficulty, she was often too busy to respond immediately. When she did eventually respond, the student had either resolved the problem herself or moved onto another client in her effort to get her work done. As a result, although students were exposed to many learning opportunities, learning was limited because they received little information on how a solution to a problem could be achieved.

One senior student complained that students' learning needs were rarely taken seriously by the midwifery staff until there was a crisis, such as the publishing of their final examination date when staff responded to the panic of the students.

> Jodie "Now the exams are here everyone suddenly realises and we panic thinking of things we haven't done. Only one person who ever kept a check on you and that was Sister X. She would say, "I think you need more V.E's. Why don't you go to the admission room for a while". (Week 55, Set D, trained 11 months, interview)

For many of the midwives the main problem with teaching students was that they did not know how it should be done. They had never been been taught how to teach and could only fall back on the ways they had been taught when they were students. If they felt threatened by the students' requirements for knowledge they would often fob them off with fairly basic information.

> Sarah "If you ask anyone a question all you get is a quick answer. Consultants are quite good at teaching---a couple. The midwives tend to push you to rush everything. They're quite good at teaching you routine things but just taught me normal".(Week 10, Set D, trained 5 weeks, antenatal clinic)

It is clear from this conversation that this student's expectations were not realistic. After a total experience of five weeks in midwifery she expected to be provided with information concerning women with problems outside of the 'normal' when she was not, as yet, fully educated about a 'normal' pregnancy. However, it was frustrating for students, eager to learn and exposed to new learning opportunities, to be told that they had insufficient education to be given information which could have clarified their understanding of a woman's problem. This type of complaint was also heard from senior students who had already received their lectures on 'high risk' pregnancy. For the senior students, frustration was created by the fact that they had not been provided with a learning opportunity which would enhance and consolidate their knowledge of diagnoses, management and decision-making. This opportunity had been lost when the midwives failed to provide them with the appropriate information.

> Linda "Their (midwives) attitude often is--because you're a student you don't need to do that right now. Its---'you need to get to basics". (Week 4, Set A, trained 15 months, labour ward)

The basic information, described by Sarah (above) as 'the normal,' was an area of knowledge in which most midwives felt secure because it was maintained through practice on a daily basis. Being provided with this type of information just perpetuated the problem for the students because they already had such information and it was more complex knowledge that they were seeking. The majority of midwives felt unable to share their feelings of inadequacy with the students and developed many strategies to cover this. Many seemed unaware of the knowledge they had to offer students and/or lacked the confidence to pass it along.

Another problem for student learning was that many of the midwives subscribed to the belief that exposure to the clinical environment could be equated with experience and learning. Watson (1991) differentiates among exposure to an event, experience and

learning. She describes experience not as something one is exposed to but as something which creates a change in behaviour or increases depth in one's knowledge. She suggests that exposure does not necessarily lead to experience or learning but to obtain experience requires that some learning takes place. A student does not have to be exposed to an event for learning to take place but does need to be exposed to an event for it to provide experience.

5.0.4.3 The Numbers Game

Many of the students would refer to the number of skills they had obtained as if this automatically conferred an expertise on them. One of the senior students discussed the number of palpations she had done but did not address the amount of confidence she felt when performing the skill.

> Peggy "I have 160 palpations. I need to get a lot signed but no one has checked them for me. I was offered some supervision this week but I didn't want it". (Week 5, Set A, trained 15 months, antenatal clinic)

Observation of this student revealed that she did not feel confident in her palpations on women when the assessment was a little more complex than usual . These were palpations where the women appeared to have excess amniotic fluid, where they were obese and often when the women were in their second trimester instead of their third. Another senior student did complain that she was not feeling confident with some of her skills.

> Bronwen "I'm not feeling that good about my V.E's. Once it gets to be 6 centimeters — well — even 4 centimeters. I have trouble even though I've done 24". (Week 5, Set B, trained 9 months, labour ward)

As Watson (1991) points out, the term 'experience' is often used as a euphemism for learning. This was clearly evident in the clinical area where midwives assumed learning had taken place if the student was exposed to a clinical event. Even the students placed credence on this idea by assuming that the more times they had practised a skill the more experience and thus, the more learning, they had obtained.

The numbers game was also perpetuated by the midwives. When first meeting a student they would often ask how many skills she had signed off in her book. Once past a certain

number the midwife would make an assumption that the student was competent enough to continue on her own. The midwife rarely validated this assumption with the student. If she did, the question was asked in such a way that the student felt compelled to subscribe to a feeling of confidence that she did not feel.

Ida, who was close to completing her course at the time when I interviewed her, was very concerned about staff expectations that she would supervise junior students once she had qualified. Given the skills that she possessed at that time, she felt that such expectations were a little unfair on both herself, and the student.

> "I don't feel very confident now about the labour ward and doing deliveries — certainly not about students. I can't see how I can be expected to teach a student who's having her 40th delivery when I've just had 40 myself". (Week 26, Set B, trained 15 months, community)

'Trial and error' was not only confined to the performance of clinical skills but also to the possession of information with which to counsel the client. Students were often sent to assist a woman with breast feeding with the words, 'you go and try and if you can't manage come back and get me'. By the time the student had finished 'trying', the woman was often in tears and threatening to put the baby on the bottle, the baby was screaming with rage and the student was wondering if, after all, she was in the right profession.

The paucity of information provided for students concerning the emotional aspects of midwifery and counselling supports Davis' (1983) results from a study of student nurses. He found that only 50% of students felt adequately prepared for the emotional aspects of nursing in contrast to many of their tutors who thought the subject had been adequately covered. Many midwives also had difficulty dealing with emotional issues in the clinical area and usually avoided them when possible. As a result, students were rarely exposed to strategies for counselling women with emotional problems and lacked confidence in this area of practice..

Summary

Davis (1983) views nurse training as the process of becoming a nurse. He suggests that researchers have shown that the relationship between nurse learners and those responsible for influencing them during their training is of great importance (Olesen and Whittaker,

1968; Lange, 1972; Lamond, 1974). What is of equal importance is who controls the learning environment.

In this study, the midwives and the medical staff controlled the learning environment and limited student opportunities to practice. Some of the opportunities were limited by organisational factors such as shortage of staff and time for teaching plus a lack of commitment by the organisation to student education. Shortage of staff led to an increased use of students as service staff rather than as learners and this was compounded by the lack of motivation for teaching demonstrated by some midwives.

Competency for the student meant having the opportunity to fully participate in the care of women and involved the continued practice of her skills. The opportunities to practice skills were rarely limited. What was limited was the opportunity for the student to obtain supervision and feedback with which to improve her performance. The opportunity to know whether she was performing in an appropriate manner. The lack of priority placed by the institution on learning meant that the students' main method of learning was by trial and error. The trial and error approach ranged from students being thrown in with no prior learning to a limited number of demonstrations with no evaluation or feedback of the student's performance.

There was little recognition for the fact that when midwives were not present with the student, a learning opportunity had been lost (Schon,1988). Midwives perceived a need to teach students but often with the objective of the students providing care because of the shortage of midwives. Many midwives did not recognise that not only did this behaviour produce students who were dependent upon them for decisions and the solution to problems but also created midwives who felt very uncertain of their skills. Such uncertainty was reflected in their care of the women which could be compromised by a lack of confidence.

> Merrill "I would have liked to have a senior midwife working with me. I often feel the care would have been better if I had. I don't feel confident about saying, 'everything's fine' — keeping someone going in labour. With a lot of them the care is physical and mechanical while others teach really well— but I didn't experience that". (Week 13, Set A, trained 17 months, interview)

Learning was negatively affected by inappropriate communications with midwifery staff and this will be discussed later in Chapter Nine. However, there were teaching strategies which enhanced student learning just as the lack of feedback and the lack of time to reflect on their performance inhibited learning. These areas will discussed in the next chapter along with a discussion of the learning style of the student.

CHAPTER SIX

FACTORS AFFECTING STUDENT LEARNING

This chapter will focus on the creative teaching strategies which emerged from the data and which midwives used to help students learn. Such strategies were devised by midwives with little assistance from the school. Other factors which were also implicated in learning were the students' learning styles and the ward climate. While not dealt with in depth, the students' learning styles have been ascertained from their own perceptions rather than through a learning style inventory, such as that produced by Kolb (1984). The role of the ward climate and its effect on students' learning in terms of learning opportunities is quite clear. What is not clear is how much a student's learning style is affected by the ward.

It has been suggested that reflective time is necessary for effective learning to take place (Schon, 1988). The role of reflection in learning was not fully understood by midwives and therefore time for this activity was rarely provided. To assist in reflective activity, students required evaluation and feedback from midwives in order to correct inappropriate learning. Many midwives evaluated students but usually in terms of service needs rather than for their progress in learning.

Factors which interfered with learning were the lack of involvement by the educators in the clinical area and the lack of knowledge midwives had concerning student learning. Other factors which reduced students' opportunities for learning were hospital policies, medical interventions and the use of technology .

Barrow (1990) believes that education is distinct from training in that to educate students we have to add something different to develop their understanding. Barrow's contention is that a student often lacks the broad understanding of a problem which makes it difficult for one to identify the kinds of questions designed to elicit the required information from the experience provided. Therefore, it is the responsibility of a teacher, such as a midwife, to make the link for the student, from theory to practice. If the midwife is unable, for

whatever reason, to make the link, then the student will be unable to ask the appropriate questions for clinical learning. As Simpson (1979) points out, practical experience is important because it can promote or retard attraction or commitment to the profession that the student has chosen.

6.0 Factors Assisting Learning

Many factors assisted students in their learning and with their opportunities to learn. Some of these have already been alluded to, such as the personality of the learner, the motivation of the instructor and the time and opportunity to learn. However, the factors which will now be discussed in detail are those which appeared from the data to be the most relevant, namely the teaching strategies of the midwives, the learning styles of the students and the learning climate in the institution.

6.0.1 Teaching Strategies

Generally, midwives took an interest in teaching students and felt a responsibility for what they learned. This sense of responsibility was increased even further when the mentorship system was initiated. Midwives used several different strategies in their efforts to enable students to learn from the information and the skills they provided. The teaching of some skills required a fair amount of creativity from the midwives because they were performed without the student being able to see what she was assessing. Such skills included performing a vaginal examination and rupturing the amniotic sac of a woman in labour. A few of the midwives used visual imagery to assist the students in the performance of non-visual skills and skills with a limited visual component, such as delivering a baby .

The midwife supervising Ida used such imagery to teach her what she was feeling when performing a vaginal examination.

> Midwife "Can you feel any cervix? Imagine you're pulling a polo-necked jumper over your head".

She went onto explain to Ida how to feel around the scalp clip on the baby's head in order to identify suture lines and the dilatation of the cervix.

> Midwife "7-8 cms, very, very thin--you got that?"
> Ida "Yes--can feel that"
> Midwife "Good.Can you feel the suture or the fontanelle? Don't worry if you can't --feel about 2 o'clock"
> Ida " Can't feel it" pulls a face.
> Midwife "Don't worry,don't worry--its O.K. Practice makes perfect". (Week 5, Set B, trained 9 months, labour ward)

Visual imagery was used mainly on the labour ward to help students visualise anatomical detail which they were unable to see. One midwife described the birth canal as, 'like the S-bend' under the sink, while another likened it to a banana and still another to a snake. Whatever description was used, the students appeared to find them helpful in identifying such structures. Other midwives would take the time, when possible, usually after a skill had been performed, to draw the reproductive structures for the student and describe the process as it was happening.

The more senior midwives were also aware of the importance of visual imagery for the students' understanding. One sister on the labour ward, who had expressed an interest in my study, asked me if I thought students would learn better if they had more visual aids. She stated that the staff on the labour ward had used such aids until recently but that they had now disappeared. No one knew where they had gone or had asked the school if they knew anything about the disappearance.

Midwives working on the labour ward often had a clearer idea of what the student needed in order to learn certain skills than did midwives on the postnatal or antenatal wards.

> Sister "Like with V.E's. Some students would say would you mind if I do this first and then you can tell me if you find something different to what I'm saying, and some students would say it the other way, opposite of that. So we have to judge each student for their capabilities". (Week 21, labour ward)

Students found the midwives who were the most helpful were those who asked how they wanted to proceed with a skill, such as a vaginal examination. However, given some of the constraints, such as the woman not wishing the procedure to be repeated by the student, opportunities to perform vaginal examinations which could be checked by the midwife were not always available.

> Violet "Midwives would do V.E.'s and not have a chance to let me do it because they were sore. (the women). I've done 15 V.E.'s but I'm not sure about them. I found it easier to let them do it first and then they could guide me". (Week 9, Set C, trained 4 months, postnatal ward)

It was not clear from this conversation whether this was a procedure Violet requested from the midwife or whether this was the way the midwife worked and it was accepted by the student. Merril however, was quite clear about her preferences.

> Merril "I like to do a V.E. at the time with someone talking me through it and then they check it after to verify what I've found. Most of the time they would ask if I wanted to do it first then they would tell me what they find but didn't talk me through it. Never went into why there was a difference between our findings". (Week 11, Set A, trained 16 months, labour ward)

'Talking through' skills was commonly requested by students but not always adhered to by the midwife especially if she was in a hurry. Many students complained about this lack of information as they were left not knowing whether they had correctly performed the skill. 'Talking through' was most important to the students in the junior stages of their training when they had little idea of what they were feeling or how certain processes worked.

> Linda "I think you should be talked through more in the early period so that you know what you are doing. I've never had that". (Week 8, Set A, trained 15 months, labour ward)

The students rarely identified the need for a well educated midwife but the personality of the midwife was deemed to be important. Midwives who were responsive to student's questions, allowed the senior students some independence and were 'laid back' in their practice, were preferred to those midwives without such attributes.

> Linda "Someone like Y is good because she lets you get on with it--explains what she's doing. Doesn't need much prompting to get information. You feel you can ask a question that may seem totally stupid." (Week 8, Set A, trained 15 months, labour ward)

As the students advanced in their programme they began to seek more independence in their practice. This was especially true for the students who were fairly senior and close to completing their programme. Unfortunately, for many of them such independence was not forthcoming.

> Linda "I would much rather be on my own. I worked with a midwife yesterday who said 'I'm here---but I'm not here'and she left me to get on with it. I mean she was there if I wanted her but she didn't interfere--I left here on a real high--and now this. I'm not managing this case, she is (midwife)". (Week 8, Set A, trained 15 months, labour ward)

Linda, who had almost completed her training at this stage, admitted to 'switching off' when she was not responsible for the care of a woman. She found it so boring when she was not making decisions that she rarely paid attention to what the midwife was doing. As a result, little effective learning was taking place at a time when learning should have been optimum.

Ogier (1989) noted that senior student nurses in her study became frustrated by their inability to plan their work and make their own decisions. In this study, students rarely expressed frustration, but did recognise a need to be on their own if they were to learn how to make decisions concerning the care of women. Although left to their own devices on the wards and in the clinic, they continued to be more closely supervised on the labour ward, even though some of the sisters recognised a need to allow the students more independence.

> Sister "I think that as they're getting senior it's important that they're left on their own and then the midwife always checks it (V.E's) after them to make sure they've got it right".

The amount of supervision the students received was not always the important factor. The important factor appeared to be whether the midwife felt able to trust them with the responsibility of caring for a woman by themselves. Some midwives felt quite comfortable allowing the students such freedom but they were usually the midwives who were the most confident in their own performance. Midwives who were less confident were

perceived by students to have found other ways to allow the students a measure of independence. Marion expressed a desire for the midwives to appear to be more interested in teaching students at the same time as allowing them more responsibility.

> Marion "Have the midwives take an interest in you. Half the time they won't let you do something yourself but as soon as you have your own patient —then they let you get on with it. I suppose somehow they don't feel responsible when its your patient". (Week 57, Set C, trained 16 months, interview)

There was an understandable concern on the part of the midwives at allowing the students freedom to make decisions in such a critical area of care. After all, the midwife was ultimately responsible for the student's practice and any errors she made. For midwives who were not confident in their practice, having such responsiblity for a student was very stressful, especially when they often felt unsupported by the senior midwives, if problems arose. Even the senior students recognised this problem because several of them voiced their concerns at the prospect of being responsible for students as soon as they had qualified.

6.0.2 Learning Styles

A second factor which may have had an effect on the efficacy of student learning was their learning style. Learning styles have not been identified according to any one definition for several reasons. First, as part of the informal interview students were asked to describe what they perceived to be their own learning style. Second, this was one area that emerged more strongly from the data after I had left the field and therefore I was unable to collect additional field data to support more identifiable styles. As can be expected some students were better able to describe their learning styles than others. With the limited amount of information provided by the student, I was only able to identify the learning styles in the way in which they appeared in the data, active or passive.

It is difficult to know how much a student's learning style facilitated progress in learning because many students attempted to adapt to whatever learning opportunities were available, the way in which teaching was provided and the requirements of the midwives. This type of adaptation left little room for individuality until the students were more senior and felt more confident about negotiating for opportunities to meet their learning needs.

The characteristics and motivation of a learner are important in any learning process. The learner's response to new experiences is determined by past experiences. If the learner was successful in the past, she will enter more fully into a new context and get more from the experience. She is also more likely to find it rewarding. Boud et al (1985) suggest that previous negative experiences can create feelings of discomfort in the student when faced with a similar situation. Feelings of discomfort can interfere with learning if the student becomes preoccupied with the emotional responses invoked by the memory. However, Boud goes on to suggest that a desire to learn for a purpose can assist in overcoming obstacles and inhibitions.

6.0.2.1 Active Learner

Main (1985) discusses four learning styles which she decribed as activist, reflector, theorist and pragmatist. An individual with an activist style learns best from new experiences, change, excitement and involvement in the experience. A reflector is a person who stands back from events, observes and considers her options before acting within her own time frame. For a person considered to be a theorist, the use of models and concepts will best facilitate learning and will assist the individual in analysing a situation to which she will apply her intellect in solving the problem. The pragmatist learns best when she can link theory to practice and have the opportunity to immediately implement her learning as practice.

> Merril "Working on a one to one with somebody and them demonstrating and then you doing it with them supervising. I think it's probably the best way. Because so much of it is practical. You can't learn it from a textbook, you've got to have the practice". (Week 10, Set A, trained 16 months, labour ward)

Merril clearly identified herself as having some of the attributes assigned to an activist style of learning. She goes on to describe how difficult she finds the reflective and abstract types of learning,

> Merril I'm one you can sit and lecture me for days and days and it goes in one ear and out the other. I need to practice. Constructive teaching and practice are the methods by which I learn best".

Kolb (1984) defined learning style as the way individuals organise information and experience. He viewed learning styles as acquired, consistent patterns of learner-

environment interaction. He also defined active learners as using an accommodative learning style. For this style, learning is obtained through concrete experience and active experimentation with an orientation to task accomplishment by risk taking, trial and error and adaptation to changing situations. The majority of students in this study appeared to favour this type of learning style.

Performing a new skill does not always provide the required ongoing information which can be necessary in order for the student to correct her performance. It is often not until the performance is complete that the student becomes aware that the outcome is not the one she expected. Then she must attempt to go back over the steps to identify where she went wrong. This is often a difficult step to take without feedback from someone who has expertise in the area and who has observed the student's performance, in this case, the midwife.

> Joanne "How I learnt was from going into the wards and checking the patients and if someone has a problem you go out and ask someone to check and they come in and teach you. Get lots of different ideas because of the different approaches of the midwives. I'm not sure that's good". (Week 12, Set A, trained 16 months, interview)

The above approach was quite different from that described by Fiona who liked to read up on the subject first in comparison to Mandy who liked to begin with a discussion.

> Fiona "I learn by reading and then practice. For example on the labour ward, just reading about a V.E and then you actually do it, you learn. It's practice. Obviously, you have to watch and then you do it and bring out everything you've seen and of course you need the feedback. Sometimes just don't get feedback which is disheartening". (Week 53, Set C, trained 16 months, interview)

> Mandy "Discussion first. An understanding of different muscle layers, that sort of thing. And initially er — a demonstration of the actual physical examination of the baby and the mother. All that had to be asked for it wasn't automatically part of your introduction to the ward". (Week 53, Set C. trained 16 months, interview)

Of course the two students do appear to be discussing different aspects of knowledge required for the clinical area. Fiona is discussing information connected to performing a skill while Mandy is identifying more complex material required indirectly in order to perform a skill. It may be that the direct learning required to perform a skill needs to be addressed in an 'active' fashion while the indirect learning can be obtained through a more 'passive' learning style. Regardless of the learning required these anecdotes would appear to contain some of the elements described by Main (1985) as constituting a pragmatic approach. It was clear that for most of the students a demonstration by the midwife was required followed by a performance which was supervised and provided the student with feedback.

It was difficult to obtain an idea of the learning style of some students because they felt that the best way for them to obtain learning experiences was to behave in a compliant fashion. It is difficult to know, given the structure and the heirarchy of the institution, whether this was the student's normal learning style or whether she had adapted it to meet the expressed needs of the institution. Whatever the answer, a few students were labelled as a passive learners because of their behaviour.

6.0.2.2 Passive Learner

Linda was a student who identified herself as very compliant because she was easily dissuaded from a course of action by the midwives. Linda would fit one criterion for the accommodative learning style in that she accommodated to the learning situation and carried out tasks as they were identified by the midwife.

> Linda "I'm too compliant. Always being told you don't need to know this at your stage. I used to ask a lot of questions and midwives, especially newly-qualified ones, would say, 'you don't need to know that at your stage. You are asking too many complicated things. You are only at the beginning of your training'. I'm like most of the others except one or two who are quite pushy". (Week 8, Set A, trained 16 months, labour ward)

What is interesting to note is that this was one of the students who was perceived by staff on her previous ward as being too confident. Both Linda and another student were accused of not complying with the routines of the ward and the wishes of the staff. Despite this discrepancy Linda considered anyone who persisted in demanding answers to

questions as 'pushy'. My interpretation of Linda's behaviour was that she felt it necessary at times to question staff and when she did so the staff felt threatened. Unfortunately, she was not aware of this effect on members of the staff and saw herself as a 'compliant' person.

Highfield (1988) describes students who display 'wait and see' characteristics as assimilators. In her study she found that the predominant learning style among students was that of assimilation. Assimilators were students who combined watching (reflection) and thinking (abstract conceptualisation). However, with the limited and conflicting information available on Linda's learning style it was difficult to characterise her as an assimilator.

It was clear from my observations that a couple of other students did display the characteristics of an assimilator. These were students who even in the early part of their training refused to practise their skills in ways other than that taught them by the school. In the antenatal clinic they refused to be rushed by the midwives and took their time when booking the women in order that they could talk to them in the way in which they had been taught. They gave themselves time to reflect on the information they had gathered and to make decisions on its outcome.

These students stood out from the others in that their learning style appeared quite sedentary in comparison to their colleagues who were much more active. Kolb (1984) suggests that assimilators are less active and task oriented and are more passive in their approach to learning. They organise information but are not as involved in the application of information. Authors of three studies have identified accommodative and divergent styles as the most common among nurses and nursing students. Two of the authors found that some nursing students learned best when actively involved in a learning situations and others learned best by passively watching (Kolb, 1976; Laschinger and Boss, 1984; Main, 1985).

Kolb and Fry (1975) have hypothesised a four stage learning cycle and suggest that to be effective, learners need to have four different types of abilities which correspond to the stages of the cycle. The cycle begins with concrete learning experiences which provide the basis for observations and reflection. These are assimilated into theory construction and the formation of hypotheses which provide impetus for new action. The final stage

consists of experimentation and testing of the newly formulated theories. Kolb (1984) goes on to suggest that most people use a combination of these abilities.

O'Kell (1988) studied nursing students using Kolb's learning style inventory and found that the majority were convergers or accommodators. Convergers excelled in abstract concepts and active experimentation while accommodators excelled in concrete experience and active experimentation. Both types represent an active approach to learning. Highfield (1988) found that progression through nursing education did not affect the student's learning style. It is possible that although learning style may not change it may be accommodated to the opportunities provided by the organisation.

What was clear was that most of the students used a combination of observation, reflection and active participation to learn skills. Again, which combination was emphasised over the other may have been due to how many demonstrations a student received and the amount of feedback from the midwife.

> Janet "No, watching someone else do it, I think--the most I think. And that being repeated and then someone watching me to see that I was doing it right until I felt confident in what I was doing". (Week 9, Set B, trained 10 months, labour ward)

Given the results of this research one would expect that whatever learning styles students exhibited in nursing would have been continued throughout their midwifery training. However, it is possible that styles suitable for learning experiences in nursing may not be as useful for acquiring midwifery skills. While one must apply theories of learning styles with caution it's application can be useful in alerting teachers and mentors, such as midwives, to the fact that students do not all learn in the same way. Indeed mentors need to be aware that they themselves have different learning styles, whatever they may be, and these styles may not enable them to offer teaching opportunities which are useful to all students without first identifying their needs.

Theories of learning styles have been presented here in order for the reader to understand that although this category was not saturated according to grounded theory there is evidence in the literature for the usefulness of such an application. It is important however to identify some of the difficulties not addressed by the current theorists. One of these relates to the difficulty of identifying and applying the theories of learning styles when

theorists cannot agree on the specific content or even the terminology of the four styles. Main (1985) does not provide the detail or the research supplied by Kolb (1984) but does agree in a general sense on the content of the four styles albeit referring to them by different names. In addition, neither theorist addresses the need for reflection by all students regardless of their learning styles. Reflection has been identified as a component of only two out of the four learning styles identified by Kolb and Fry (1975) which would suggest that the remaining two rely more on a trial and error approach.

Part of the criticism of self report learning style inventories is directed at the fact that the choice of learning styles by an individual is a perceptual choice and may not reflect the individual's true approach to learning. It is possible that in completing the self report individuals emphasise an idealised learning approach because they perceive such an approach to demonstrate flexibility and abstract thinking, abilities which tend to be prized over a pragmatic, more concrete approach. It may also be that the learning styles identified by Kolb and Main are actually personality styles of students rather than cognitive learning styles. The identification of such difficulties tends to be supported by those researchers who have attemped to use learnng theories and obtained results which were not congruent with all of Kolb's hypotheses.

Researchers, such as Highfield (1988), Laschinger and Boss (1984) and Merrit (1983) have applied Kolb's theory of learning styles to nursing students in a less than critical fashion. The outcome of their applications have not been consistent. All of the students selected were from university programmes although two were from the United States and one from Canada. Despite the incongruency of their results none of them addressed the issue that what may have been at fault was the self report learning style inventory. Indeed none of them addressed the fact that there were inconsistencies with the theory tending to only identify the hypotheses which suported their results. The predominant learning style of students in Highfield's study was that of assimilation, a combination of reflective observation and abstract conceptualisation. For Laschinger and Boss and Merrit (Canada & U.S) the predominant styles were those of accommodators or divergers. In the former study all four learning styles were represented in the student population which does not support Kolb's theory that students are attracted to a discipline which provides learning experiences congruent with their learning style.

Some students had high expectations of the clinical area and felt that they were not learning as fast as they should. The need to learn fast came partly from the anxiety

associated with not knowing how to perform specific skills and partly from the expectation that learning would be constant.

> Florence "I learned a little last week but it was not enough. I want to know everything at once. Doing that booking really frightened me". (Week 7, Set D, trained 2 weeks, antenatal clinic)

> Susan "I find I'm not learning enough — don't feel I've learnt as much as in the labour ward. Maybe it's that there's not much to postnatal care". (Week 9, Set D, trained 4 weeks, postnatal ward)

The anxiety created by a lack of knowledge was probably due to the nature of the environment in which the students worked and its demands for a very active participation in care. The shortage of staff often left the student with a view of herself as a member of the staff rather than in the learner role. Many students found this to be threatening.

> Marion "We've gone from 4 to 2 staff — just Y- and me — but we now have two agency nurses". (Week 29, Set C, trained 8 months, postnatal ward)

6.0.3 Ward Climate

It has been clearly identified that one of the factors which could facilitate or inhibit learning in is the ward climate (Howe, 1981; Jacka and Lewin, 1987; Ogier, 1989). All of these researchers focused on the training of nurses so their results must be applied with caution. Motivation of the midwives to teach and the priority the institution placed on education were all significant factors identified by the nurse researchers with regard to nursing and were supported in this study. other factors which they identified and were also found in this study was the fact that students were able to identify fairly consistently which areas provided them with the most learning opportunities and teaching. The community was declared the best place for initially learning skills because of the one to one teaching involved and the feedback provided by the midwife.

> Myrtle "Learnt most of my palpations on the community. A bit slow but you get a lot of experience. You've got to be outgoing. Not be afraid to ask. I can see on labour ward if you dont ask--depending on who you're working with — if you don't ask they don't offer any teaching". (Week 55, Set B, qualified 2 months, interview)

The ward climate was important for students in that it had an influence on the type of learning that took place. Climate is not a single entity but a composite of a variety of factors, such as the administrative structure, nature of the curriculum, aims of education, methods of instruction and discipline, the teacher and the student. The teacher is often viewed as a central factor because some of the other factors are to some degree subject to her control (Vollman, 1989). However, the teacher in this study was not one imposed from the outside as in Vollman's study nor was it a person who had been professionally trained for the role. The teacher was whichever midwife was working with the student. She was often chosen for convenience rather than because she had special attributes for working with the student, such as teaching and communicating skills. Convenience usually related to the fact that she was present on the same shift as the student.

Wherever the students worked, their perception was that they had to initiate interactions for teaching. Usually the community midwives taught without being asked but this was clearly not the case for the labour ward.

> Ginny "Its hopeless on the labour ward. I've never worked there with my mentor. Some girls don't know who their's is. On the postnatal ward not much interaction. Tend to get dumped there and no one tells you anything. Best ward for teaching is Z-. They are really geared up for it. Perhaps because its not really a busy ward but brilliant. Also had a tutor on the postnatal ward in a teaching capacity one day and the next day for a chat --but that was her approach". (Week 27, Set B, trained 15 months, antenatal ward)

Another ward clearly identified as a good area for teaching was the antenatal ward on the first floor. Students were quick to identify that although the ward was not busy the main reason for its positive image was its focus on teaching. This was one of the two wards where teaching time was structured into the routine and students were always checked for the competency of their skills before they were left alone. The sister on this ward also

demonstrated to her staff a commitment to teaching and a clear expectation that all staff would participate.

> Bronwen "First floor is good for skills teaching and knowledge sessions. Mentor system is good there and they're really working on it. On the antenatal ward you never did a check on your own unless sister had checked it". (Week 4, Set B, trained 9 months, labour ward)

Generally most of the students felt that teaching was not a priority and that they were treated as part of service and not students to be educated. Most of their comments are summarised in what Linda had to say

> "I find you have to learn yourself anyway--there's not much teaching and its not up to much on labour ward. Considering it's a teaching hospital the teaching is poor -- it's more trial and error". (Week 8, Set A, trained 16 months, labour ward)

The senior students were very concerned about whether they were competent enough in their skills to work elsewhere.

> Joanne "It bothered me earlier on in training that we were only trained for high tech and not doing it naturally like in other centres. But now I've accepted that I'll have to go somewhere else to get natural midwifery." (Week 13, Set A, trained 17 months, postnatal ward)

This acceptance of inadequate learning conditions was fairly general and represented a feeling of helplessness at effecting change. While they were all asked to evaluate their programmme at the end, each set recognised that their complaints were little different from those of sets who had gone before. The complaints were made before educational and invited clinical staff, written up, and the information circulated to the wards but there seemed little follow-up by the school to ensure that the clinical areas made changes that were consistent with the suggestions from the students.

> Bronwen "I remember we had this questionnaire, an evaluation of the course and everything. It said 'do you feel confident as a midwife' and I think everyone in the set said, no, especially on labour ward. We didn't have enough labour ward experience really. I notice that midwives who come from other hospitals, like they trained in Scotland or elsewhere, they seem much more confident and they knew what their role was". (Week 55, Set B, qualified 4 months, interview)

6.0.4 Reflection

Reflection is a conscious, cognitive process that enables one to revisit one's memory of an event in order to extract emotional and substantive content which can be then be compared in a positive or negative way with one's present knowledge in order to expand that knowledge. Several authors have identified the need for reflection in order that the learner may obtain the optimum learning from an experience (Boud et al, 1985; Boud, 1988, Dewey, 1933; Marton and Saljo, 1976; Schon, 1988). Reflection assists the learner with the identification of other learning one requires before one is ready to undergo further experiences. In order to maximise learning the learner has to be aware of the importance of reflection for learning and how it can be facilitated.

In the context of learning, reflection is a generic term for intellectual and affective activities in which individuals engage to explore their experiences and to gain understanding (Boud et al, 1985). It is a form of response of the learner to experience which is integral to every aspect of learning and touches most processes of the mind (pp.7 & 18). Boud (1988) provides information on what he considers to be the steps involved in reflection. He suggests that following an experience the individual should return to the memory of that experience, recall the details, attend to feelings and re-evaluate the experience. Re-evaluation contains four components; asociation of the original experience with present knowledge; integration of meaningful associations and the discarding of those which are not; validation of ideas and feelings which have been integrated by assessing them against existing knowledge; and finally appropriation, taking on the new knowledge as part of our functioning.

As can be seen from this definition it does not contain the specificity to be of use to a researcher attempting to apply reflection in a critical fashion to a learning situation. Information which would have been helpful is how soon and how long does one need to

reflect in order to gain insights into experience, what quality of mentorship should be provided at different levels of student training and at what stage can we expect a student to be able to reflect with little assistance? Boud (1988) has suggested that time is the major factor in reflection and that if this is provided reflection could take place. Time may not be a major factor in a clinical situation where learning often takes place under stress, and where errors in judgement may prejudice the health of others and produce negative feelings to future clinical learning experiences. In addition Boud and his coauthors have not researched their theory to assess its validity. Such research would have been useful in identifying inconsistencies and the need for more specific criteria on what reflection entails.

Schon (1988) also supports the need for reflection but addresses it from a different perspective. Schon believes that reflection is a part of all thought processess and occurs with everything that an individual undertakes. He talks about a reflective practicum, reflective dialogue, reflective inquiry and reflection-in-action. The same criticism of lack of specificity applies here as with Boud. Schon makes a greater attempt than Boud at the practical application of reflection when dealing with students learning skills in counselling,, architecture and city planning. The difficulty with Schon's approach to reflection is that his definition is too broad and it is often difficult to differentiate it from the cognitive process of thinking. As a result his application is labour intensive requiring the constant attendance of a teacher at all aspects of the student's training. In addition, his suggestion that the time spent on reflection should equal the time spent on clinical activity is not one which lends itself to most training programmes in terms of cost efficiency.

The usefulness of the approaches of these two theorists lies in the different attributes each brings to the subject of reflection. Boud provides some depth to the definition of reflection and supplies us with information on the cognitive processes involved. Schon provides the time element missing from Boud's definition in that he considers that reflection should take place as soon as possible after an experience has occurred. In addition he supports the need for an educator to be present for guidance in all new activities. He also identified the need for reflection to be built into the curriculum of all educational programmes whether they addressed clinical or classroom learning.

It occurred to me when analysing my data that there was little time for students to think in order for them to learn from their days' activities. In discussing this with a midwifery teacher she identified Schon as providing some helpful ideas on this subject. An

examination of Schon's writings on reflection along with those of Boud and his colleagues provided considerable insight into the relevance of reflection to learning. It is unfortunate that I did not recognise the need to gather more data on this subject prior to leaving the field as it may have helped me to specifically define the approaches used by the students.

Adoption of a reflective approach has been associated with a deep approach to learning. Ference Marton first identified the deep and the surface approaches to learning in classroom situations (Marton and Saljo, 1976). A learner who exhibits the deep approach has been described as being directed toward the intentional content of the material, the comprehension of what the author is trying to say in the text. The surface approach is directed toward learning the actual information with no interaction with the content.

Although Marton and Saljo's work was directed at classroom learning there would appear to be a general application with learning in the clinical area. Marton and Saljo's theories emerged as a result of both qualitative and quantitative research with students in higher education institutions. The results of their two to five year longitudinal study produced a great deal of specific content on what each approach entails and how and when it is used by the student. Their work has since been expanded upon to include a middle ground approach, called the strategic approach. This approach is taken by students whose intention is to obtain the highest possible grades for the least expended effort. One of the aspects of their work which was helpful to this study was the idea that students change their approach according to the requirements of the material they have to learn and according to the pressures to which they are exposed.

Students in this study tended to demonstrate either a surface or a strategic approach to learning. This was exhibited in their efforts to please staff by offering to perform extra tasks for them and also in their efforts to please the midwifery teachers by studying for their tests. In addition they would attempt to 'copy' midwive's activities which they were often unable, when asked, to integrate with the theory learned in the school. Whether this behaviour was the result of a conscious attempt to learn the material in a specific fashion or whether it was due to the pressure of the workplace is difficult to identify. Much of the responsibility for this could be laid with the institution and the midwives. The shortage of staff imposed time constraints which did not allow the students time for reflective activity. The midwifery teachers, as part of the institution, failed to identify whether students were applying and integrating their theory with practice. Lastly, the midwives did less than was

possible to provide reflective time and assist the student in gaining insights from reflective activities such as debriefing.

It was clear from the students' complaints about lack of teaching and lack of time, that they were aware of the need for reflection regardles of their learning style and approach to learning. Reflection needs time and this was the element often missing from the student's day. When a delivery had been completed the student had to assess the woman and the baby, wash them both, fill out the appropriate documents, enter the data into the computer and transfer the woman and her baby to the ward where she gave a report on the birthing process. When the student arrived back on the labour ward, she would often be sent to care for another woman, with little time for reflection on her previous performance. While I have only described the situation on the labour ward, such a situation was common to all clinical areas, except for the community, where debriefing was a fairly common occurrence. It was not uncommon to observe students rushing all over the place on the units in their efforts to complete their tasks in the time allotted.

Students did make attempts to reflect, when possible, on their performance and sought out staff who they felt would aid them in this procedure. A few midwives did perceive the importance of debriefing and when possible took the student to one side to talk through her performance. Unfortunately, many senior midwives did not perceive such a need and would quickly find other work for midwives and students who were found talking in the hallways.

6.0.5 Evaluation and Feedback

One way in which midwives could assist students with reflective activity is through evaluation and feedback. Evaluation not only informs the midwife of the student's knowledge and skills but also provides the student with insight into how much she has achieved in her programme. Feedback is a very necessary component of evaluation because without it students' learning is less than optimum.

Schon (1991) states that students learn by practising skills until they become adept and that they are helped to do so by senior practitioners who initiate them into the traditions of practice. Dewey (1966) suggests that students cannot be taught but they can be coached. Coaching would enable them to see for themselves, in a way that makes sense to them, the skills used and the outcomes achieved. In both these statements there is an implicit

recognition of the role of the instructor or coach in ensuring that whatever the student is exposed to must be meaningful in order to be learned.

To render information meaningful, students required feedback on their performance from the midwives. Such information could only be provided by midwives if they had first evaluated the students. Midwives generally believed in the value of evaluation and feedback and most of them assured me that it was always done. However, the students complained that it was rarely done and this was congruent with my observations.

> Ida "They just left me to get on with it. Maybe they drew some conclusions in their own head as to how I was getting on but they never communicated much criticism or encouragement really, one way or the other". (Week 7, Set B, trained 9 months, labour ward)

Students have to practise their skills in order to learn how to 'do', but such learning has to be focused. Students need help with learning how to learn. The student tries to do what she seeks to learn and reveals through her performance what she understands or misunderstands. It is only through evaluation that the midwife can identify whether learning has been successful. The instructor then needs to respond with advice, criticism, explanation and description which, to be effective must be keyed to the student's level of understanding (Schon, 1991). If midwives did provide explanation and criticism it was often at a level far higher than the students were capable of comprehending.

> Mandy "Understanding what is being taught depends on the situation. On the labour ward some of it was too advanced for me". (Week 54, Set C, trained 16 months, interview)

Students identified the importance of evaluation and feedback after they had practised a skill, even when they had a midwife who provided them with appropriate learning opportunities.

> Janet "With the deliveries I got a lot of help. Worked with the same midwife and that was good and after the delivery I like to talk about it with whoever is with me. Ask if there's anything I could have done better---if I did alright". (Week 5, Set B, trained 10 months, labour ward)

What the student is describing here is debriefing, one method of reflective activity. Pearson and Smith (1985) discuss the steps involved in debriefing but unfortunately do not provide a specific definition. As a result it is difficult to isolate debriefing from other forms of reflective activity other than the fact that it is structured and the leader of the procedure requires specific skills. Debriefing for the purposes of this study will be reflection on experience that is guided by an clinical expert (the midwife) who will assist the student in extracting as much learning from her clinical experience as is possible. Such learning will include the exploration of feelings as well as behaviours demonstrated by the student during the experience. Students found this type of activity very helpful but unfortunately, the opportunity to debrief was not provided as often as it was required. Complaints about lack of feedback were very common among students. Again, as with teaching, some clinical areas were better than others with evaluating students and providing feedback.

The importance of evaluation seemed to be emphasised more in the areas where the students had the potential to do harm, such as the labour ward, than in areas where the potential for such activity was limited. On the labour ward the students' skills were evaluated at the time that they performed them, while in the antenatal clinic the students were rarely evaluated on their skills after the first two or three demonstrations. The students' most common complaint of the labour ward was that they were often evaluated they were rarely provided with feedback.

> Maureen (doing a vaginal examination) "Taken up--quite a lot of cervix — anterior and down this side — 8 centimetres — at spines — can't define the sutures — bit of caput".
> Sister (examines woman) "Right K- you're not quite ready to deliver this baby, do you want something for pain?"
> Maureen to Sister "What?"
> Sister "Cervix all round, I think about six — is the clip working?" (electrode) (Week 7, Set C, trained 9 months)

A certain number of skills, such as one hundred antenatal palpations, were required by the English National Board and had to be checked by the midwife in order that she could sign that they were performed correctly by the student. Many of the midwives in the antenatal clinic would sign for such skills without always having seen the student perform them or assessing that the student was correct in her assessment.

One of the community midwives admitted that knowing the level at which to teach a student was often a problem for her. She felt that students also needed to give midwives feedback in order for the midwives to be able teach effectively. Some of the students felt too intimidated to provide this.

> "I mean when you've been doing it for so long you sometimes forget that they don't really know very much. I think when you're teaching you need feedback you're hoping that what you tell them is what they want to know because obviously you can tell them things they know and it must be boring (laughter)".

Midwives on the labour ward also identified this as a problem. Their problem was due partly to the fact that they had several students working there who were practising at different levels. During a busy shift remembering which student was a beginner and who was the more experienced was very difficult for the sister in charge and as a result she sometimes assigned students inappropriately.

> Sister on labour ward "The most common problem with teaching students I find is that if I misunderstand what level of training the student is at, and I perhaps start talking to her about something she knows nothing about and couldn't possibly be expected to. That, I think, is as far as I'm concerned, the commonest reason for a student not understanding". (Week 26, labour ward)

This, I believe, was a fairly common problem generally recognised by students but not always by the staff. Some midwives did attempt to ascertain the student's level of understanding and expertise but many did not appear to perceive the need. Unfortunately, the education staff did not see it as their responsibility to assist the clinical staff with the identification and solution to this problem.

One way in which the staff could have been assisted by the education department was in understanding the importance of evaluation for the student. While recognising that it had importance, most midwives perceived it to be important only for the knowledge that it provided them on the student's level of expertise. It was unfortunate that many did not realise the importance of sharing such knowledge with the student.

> Violet "Yes, they usually evaluated us. It differed in a lot of areas actually. I'm thinking about labour ward, they definitely did and postnatal. Often they checked that you were doing it right in the first place. For example, postnatal checks differed from what you'd been taught in class but no one actually looked at you to see if you were doing it properly". (Week 23, Set C, trained 8 months, antenatal ward)

There were different ideas among staff as to what constituted an evaluation. Many of the staff did not perform ongoing evaluations of the student and often she was evaluated at the beginning of her placement on the unit and then left to continue her skills without further assessment. Sometimes an evaluation involved the physical assessment of one skill performed by a student, such as a postnatal or antenatal check. These types of skills would be checked a couple or more times by a midwife who would then leave the student to continue on her own.

> Marion "Yes definitely (they evaluated). Especially on postnatal and antenatal, usually for the first week or so. A midwife worked with us checking palpations, checking admission procedures, for example, and once she thought you were confident you were left to do it on your own. Also in the clinic as well as doing the bookings, usually you sat and listened to a midwife and then she would listen to you do a booking and then she would let you go out and do it on your own". (Week 54, Set C, trained 16 months, interview)

Certain specific skills, performed by the students, such as vaginal examinations and of course, deliveries of infants, were checked every time they were performed but, as Linda points out, the evaluations were not always used for teaching purposes.

> Linda " They checked our V.E's. Oh God, yes. They check it but they don't tell you anything. They ask what you found and that's it. You don't learn anything". (Week 8, Set A, trained 15 months, labour ward)

Staff on units such as the labour ward were often more likely to assess a student on a regular basis because of the need to allocate the student. If there were more women requiring care than there were trained midwives, the clinical level of the student became an

important criterion for how much responsibility she could be given and how long she could be left on her own. The emphasis on evaluation was for service reasons and not to facilitate education.

> Midwife "I always evaluate students' skills because I have to know how skilled they are when I allocate. Whether they need someone with them or not and how much I can give them to do and which areas I can put them into".

However, it was rare to find the service requirements articulated as a reason for evaluation.

> Sister "Yes, personally I like to, (evaluate) on a shift that I think I'm going to be working with her. Then I would like to know what her clinical capabilities are".

All of the midwives claimed to evaluate the students on a regular basis, a statement not borne out either by my observations or by students' perceptions. One of the commonest complaints of students was that evaluation was rarely done by midwives until the end of their placement, when they had little time to rectify inaccuracies in their performance. The amount of evaluation done on students on many units appeared to be related more to the midwife's conscientiousness than to stated policies for directing student education.

6.1 Factors Interfering with Learning.

Some factors have already been identified as interfering with learning and demonstrate how difficult it is to separate out what is helpful from what is not. In most situations many factors govern whether a student will learn from exposure to an event. As a result, this separation of factors is artificial and done solely for the purpose of clarity for the reader. The separation has been determined by where they have the most effect. If they are factors which assist more than hinder they have been discussed under the rubric of 'assisting'. If the factors are deemed to have hindered more than helped they have been dealt with in this section. The midwife has been discussed in both sections because her effect on learning seems to fall equally between the two.

6.1.1 Teachers and Midwives

As stated earlier one of the biggest problems for the midwife was the expectation that she could teach students with no prior knowledge of the requirements of such teaching. The

student was sent out into the clinical area with little contact between midwifery teachers and clinical staff with regard to her individual and general needs. All of the teachers had undertaken courses in advanced midwifery and education which prepared them for teaching. Despite this they seemed unable to recognise or to alter the fact that, without their assistance, the clinical staff could not be successful with clinical teaching.

Midwives who were less confident in their practice used strategies which were easily recognised for what they were, evasions. One such strategy was identified by many of the students as occurring at some stage in their training and is described here by Linda.

> Linda "Their attitude often is --because you're a student you don't need to do that right now. Its-you need to get to basics. Some midwives are approachable and you can ask them, but not the one right now. If I ask her she says 'I don't know' ". (Week 8, Set A, trained 15 months, labour ward)

Many of the midwifery teachers did recognise the need to get into the clinical area to help students integrate theory with practice but claimed that they were too busy to meet this need.

> Teacher B "I know I don't do much clinical teaching at the moment. There are constraints for tutors. Meetings, interviews, minutiae of preparation for course work, lack of secretarial assistance which would leave us free to do what we are doing". (Week 12, interview)

There is no doubt that teachers had many constraints on their time. However, a similar situation existed for the ward staff. A lack of priority and ineffective organisation in the school led to meetings which were often repetitious in content and provided no insight for the people attending them. Another problem was that some of the teachers had not been involved in clinical practice for some time and were concerned about the competency of their skills. It is interesting that midwifery teachers, confident in theory, should be concerned about their clinical practice, while the opposite was true for midwives in the service area.

Most of the teachers recognised that staff did not have the education for helping students to integrate theory with practice. Despite this, they had no plans to assist staff by working

with them on the wards They appeared to believe that a course recently initiated would provide the solution for student education by staff midwives.

> Teacher F "I actually think the theory and the practice does not get related particularly well. Partly because there aren't people on the wards with them. I don't think there are enough people around to allow the students to be supervised as much as would be ideal. I think also its probably difficult for some of the staff to teach if they're not trained properly". (Week 13, interview)

Even when lack of staff has been identified as a problem for student learning and supervision, the midwifery teachers did not perceive themselves as having the time to involve themselves in student practice. They appeared to have divorced themselves from the clinical side of teaching and felt themselves responsible only for the teaching of theory. Their attitude seemed to be that if they went onto the wards and provided teaching for the students that was just 'icing on the cake'.

One teacher did ask for a joint appointment between service and education in recognition of the need to provide clinical teaching for students. The service side welcomed the appointment and criteria were identified for where and what hours the teacher would work in the clinical area. Unfortunately, while providing a welcomed service for students for part of the week, the remainder was often spent by the teacher in the upgrading of personal clinical skills with no student present.

Midwives who were interested and motivated to teach students used whatever methods were at their disposal. Many of them were quite successful in their teaching but such successes could have been increased if teaching staff had shared with them some of the basic tenets of educating in clinical practice. Such tenets included time for reflection, the need for evaluation and constructive feedback and the need to ensure that the student as well as the midwife was confident in the student's abilities.

Midwives needed the support of the midwifery teachers to say that it was alright if they did not have all the answers for the students. Many of the insecure midwives felt unable to do this without such support. The midwives did like to see the teachers on the wards and, as one student said, when the teachers were there the staff were more likely to recognise the importance of education for the student.

Shortly before the end of this study a new course was provided for the clinical staff by the education department called the E N.B. 997. This course was to prepare midwives who would be mentors for students and was referred to as 'Teaching through Clinical Practice' It would appear from the statements of some of the staff that the course was successful in its objective of making midwives more aware of the needs of students, and in supporting midwives with their clinical teaching.

One of the senior midwives on the labour ward thought it definitely provided advantages,

> "I think the clincal training and assessment course has been good for them (midwives). Its made them more aware of things--doing teaching etc. I notice a difference".

6.1.2 Organisational Factors

These factors such as the shortage of staff and the lack of priority placed by the organisation on clinical education have already been mentioned earlier in the context of teaching. Some midwives felt that students would fare better if they were more fully prepared by the school in clinical skills prior to working in the service area.

> Midwife "Students don't get enough preparation for the ward, not the way really I think. Probably I'm subjective the way I look at the way students er-- are looked after especially on this ward with a shortage of midwives. In other words you're relying on the students specifically. When there are enough midwives yes, the students are looked after and they get enough teaching". (Week 19, postnatal ward)

One of the difficulties for the staff was the amount of clerical work and documentation required for each woman on the ward. This, coupled with the rapid turnover of clients because of a shorter hospital stay, created a heavy workload for staff over a short period of time. Probably due to such stressful working conditions, staff were rarely in the mood to teach when there was a quiet time. Most felt the need to sit and relax and participate in their own form of debriefing over the problems encountered that day and the appropriateness of their responses.

6.1.3 Policies.

Simpson (1979) suggests that one of the reasons professions like nursing are only semi-professions is because the work is done largely in organisations which define the work function and set forth the rules for carrying them out. In midwifery, as in nursing, organisational rules are encompassed in documented policies which direct the action midwives can take with women in their care. Such policies provide little scope for professional judgements informed by knowledge.

> Linda "Another problem is the hospital has so many policies. When something comes up you're told to follow policies. When you ask why such a policy, no one seems to know — often just a consultant's whim". (Week 8, Set A, trained 16 months, labour ward)

The fact that such policies were usually guidelines and not to be treated as law seemed to escape some of the staff. Students often seemed more aware of the appropriate use of policies than the staff on the labour ward.

> Ida "I waited one and a quarter hours and sister said I should have got her pushing before. There was nothing wrong with the baby — everything was fine". (Week 9, Set B, trained 10 months, labour ward)

The complaint made by this student was that she was expected, because of the unit policy, to get a woman pushing even though the woman was not ready to push the baby out. This particular policy was one that was fairly strictly adhered to by the senior midwifery staff, but frequently complained about by the junior midwives and senior students who felt that following such policies was an evasion of responsiblity on the part of the staff. While they recognised the reason for such behaviour was the safety of the mother and baby, they also recognised that when staff followed such policies it interfered with their learning opportunities and particularly their opportunities to make decisions.

The problem of policies was not only a factor on the labour ward but also on the wards and in the clinic. Healthy women attending the clinic often had to wait to see a doctor after being assessed by the midwife because they were at a certain stage of their pregnancy. After waiting for some time the women were often reassessed by an S.H.O. who had less maternity experience and education than the midwife. Fiona complained

about one situation where the woman, although healthy, was supposed to see a doctor because she was 32 weeks gestation.

> Fiona "I don't agree with that decision. I think she's perfectly alright and doesn't need to see a doctor. I think they (midwives) don't want the responsiblity". (Week 4, Set C, trained 3 months, antenatal clinic)

One of the dificulties with the midwives not taking 'responsibility' and using the policies for this purpose was that the student was not able to validate her judgment on the health and progress of the woman and the fetus. Some of the junior doctors, unsure of their practice, often felt a need to disagree with the student or the midwife's assessment, which left the student feeling even more confused. As a result, the students blamed the midwives for not taking a stand and discharging healthy women after their examination without calling in the medical staff.

6.1.4 Medical Interventions.

Not everyone identified the medical staff as interfering with student learning. Some felt that because the students had little contact with the medical staff they were unlikely to be affected by their presence. Others did not recognise how much the medical staff limited learning opportunities when they repeatedly intervened with women cared for by students. Maureen, a student half way through her training, was one who recognised the problem and complained about the medicalisation of midwifery particularly in the antenatal clinic which she felt interfered with students learning assessment skills.

> "Some get thrown in and told not to worry about palpations, the doctor will do them. Only problem is ---I've seen few in the second trimester. Only saw them in the third trimester in clinic". (Week 23, Set C, trained 10 months, antenatal ward)

As can be seen from Maureen's statement, part of the problem with medicalisation was because it was maintained by the midwives. The women seen in the antenatal clinic were usually assessed by the medical staff in their second trimester and therefore, students were actively discouraged by midwives from doing an assessment. There was no firm policy on medical staff assessment of women in their second trimester of pregnancy and what midwives were actually responding to was a rumour.

Other midwives identified the problem of medical intervention as the result of working in a hospital which had postgraduate medical training. Such training ensured that medical staff were present in the hospital on a 24 hour basis, particularly in the high risk areas, such as the special care baby unit and the labour ward.

> Midwife "Being in a maternity hospital rather than an obstetric unit. (is the problem) The student or the midwife palpates the woman or sometimes she's in the middle of palpating or doing some work with any woman and the doctors go through the same procedure or probably even throw away the midwife so they can take over the procedure because they're rushing off somewhere else. It means the poor midwife has to stand back so there's no continuity for student learning". (Week 20, labour ward)

As can be seen from the latter part of this statement, midwives appeared to feel quite helpless at effecting a change or taking charge of their own clients. This demonstrated helplessness did not help students with their skills, as it gave the impression that the medical staff were in charge. This type of attitude was most prevalent in the labour ward and in the clinic where medical staff spent the majority of their time. However, medical staff interference was also identified as a problem on the wards.

> Midwife "To a certain degree I think the doctors interfere with the student's learning particularly if they think they can give advice when it's not their place. They'll also expect a qualified person to go with them on the round when the student is actually looking after the patient and is perfectly competent to go with them. But they don't find that acceptable". (Week 52, Set A, qualified 10 months, postnatal ward)

One or two other students recognised that having medical staff around did interfere with learning some of their skills, especially in the labour ward, though they were not too sure how they were affected.

> Bronwen "I suppose the doctors do interfere with learning. Certainly they do. But I don't know how to say how. I mean if there's a problem in labour like type I dips you're supposed to report it but you know as a midwife it could be the head going down--but if you don't report it and anything happens, you're blamed. As if, 'why didn't you tell me' you know, before this happened and things like that. I think that's the sort of thing that can affect your care of the patient". (Week 53, Set B, qualified 3 months, interview)

An unexpected finding for me was that the medical staff, in particular the consultants, did teach the students when the opportunity arose. In areas such as the antenatal clinic, the students found them to be more approachable and more interested in teaching than the midwives. In the clinic, some consultants actively sought out students to teach them assessment skills and were responsible for the major part of clinical teaching of students in that area.

> Professor "Have you felt this lady's tummy?"
> Fiona "No--Do you mind if I do?"
> Professor "No, go ahead". (Week 4, Set C, trained 3 months. antenatal clinic)

The student was then asked what she found and given feedback, provided from the professor's assessment. An interesting point of note here was that neither the professor or the student felt it necessary to ask the woman's permission for a second palpation. Even Myrtle, critical of the medical staff for what she saw as 'interference', had to acknowledge that the consultants did provide teaching for the students.

> Myrtle "Best place is the consultant's clinics. If they don't have a med student, then you tell them what you've found. Learn quite a bit there". (Week 56, Set B, qualified 4 months, interview)

The midwives in the clinic also recognised the value of the medical teaching which they felt eliminated their responsibility in that area. As a result, whenever there was a lull in the clinic, they would often suggest that the students go with the consultants or the registrar in order to be taught assessment skills. They appeared to think that their priority was keping the clinic moving and not teaching students. Teaching by medical staff was

sometimes offered by midwives as a reward if students kept the women moving in the clinic and took care of the needs of the medical staff.

However, the same feelings were not expressed concerning the senior house officers (SHO's). Most midwives felt that the SHO's clinical skills were too suspect for them to teach students and not sufficient to provide the a good basis on which the midwives could make decisions.

> Sister "If they (SHO's) say 6 cms we know its going to be a while. They are too generous in their estimates. If they say 2 cms we don't bother to bring the patients up (from the ward). We know she's not doing anything. If they say 9 cms we know we have some time yet". (Week 18, labour ward)

6.1.5 Technology.

It is difficult to ascertain how much the students and the midwives were aware of the inhibiting factor of technology on clinical skills. When asked the question the majority of students agreed that technology was a problem largely because it was not used in a holistic way, but they did not always recognise that it may have affected their midwifery skills of assessment.

> Ida "I think all the machinary here or the technology here is um-- used really without having it explained very well. I think that goes for the C.T.G. as well. And as for integrating it with patient care, no, it was taught separately". (Week 56, Set B, qualified 4 months, interview)

Students accepted that they tended to focus and rely on the machinery in the labour ward rather than on their own assessment skills.

> Mandy "Yes, you do tend to learn about the machine. Yes, and I must admit you rely on it as well. You do tend to look at the machinery, don't you?" (Week 55, Set C, trained 16 months, interview)

For one of the junior students, holistic assessment appeared to mean obtaining a comprehensive understanding of the machine.

> Martha "Er-- taught about the total assessment of the patient. Went through different traces, what they meant and how the machine actually worked". (Week 57, Set E, trained 11 months, interview)

One midwifery teacher who came up to the labour ward while I was there to teach a junior student found that she was already focusing on the technology to the exclusion of the client.

> Teacher C to Jean "Don't look at that (C.T.G.). Just put your fingers on the uterus and feel the contractions.----We'll move that (machine) out of sight ". (Week 21, Set E, trained 4 weeks, labour ward)

The midwifery teacher spent some time teaching the student non-technological methods of assessing the woman's progress of labour. However, without the teacher's support or midwifery supervision on the next shift it is doubtful that the student would persist with such methods.

6.1.6 Student as 'Gofer'

Surprisingly, not many students complained of being treated as a gofer, someone to run errands for the rest of the staff. Ginny was one of the few.

> "It was 'send the student to do this or do this with the students'. You know you've been qualified for so long and running a ward and everything and this was like the real sort of lowest of the low". (Week 56, Set B, qualified 4 months, interview)

My observations revealed this treatment of students to be a fairly common phenomenon. Such treatment was common among midwifery staff and was an ongoing expectation with the medical staff. Whatever students were doing it was never considered important enough so that it could not be interrupted for her to go on an errand.

> Midwife from antenatal clinic "Oh --you're busy. You wouldn't have time to find this smear result for me would you?"

Students always felt impelled to do as the midwife wished even if they were in the middle of examining a woman, as was the case with the student above. Bronwen did drop everything and do as she was asked. When she found the result and took it to the midwife, her errand was not over. The midwife then told her to find the S.H.O and give it to her. This expectation of being able to use the student for errands disrupted the student's learning opportunities and affected her morale. The student was used to fetch medications, find laboratory results, fetch linen and borrow supplies from other wards. A fair amount of time was spent in doing these errands, and it was fairly common for the student to be taken away from the care of her clients in order to comply with the demands of the midwife. In all fairness to the midwives, they were sometimes the only ones on the ward and could not leave to do the errands themselves. However, there were other staff, such as auxillaries and ward clerks, who could have been used for many of these errands but were rarely asked.

With the medical staff, the student did not have to be told, but seemed to expect to have to cater to their needs.

> Myrtle to S.H.O "Be right with you I'm just getting the stuff for the smear". (Week 26, Set B, 14 months, antenatal clinic)

In the clinic Myrtle spent a lot of time running around getting equipment for doctors who would just stand and wait for her or other students to comply with their wishes. Such behaviour also added to the holdups in the clinic. Students were even expected to fill out the laboratory forms and any other forms which required the doctor's signature. Although many of the students resented their treatment they felt unable to rebel because the midwives gave them little support for such a rebellion and actively encouraged the students in this activity in order to keep the clinic moving. However, Janet was very upset and felt very demeaned when a registrar, requiring someone to monitor a client who was fairly low risk, said

> "Oh, that's a job for the student. She could manage that".
> (Week 55, Set B, qualified 4 months, interview)

Janet said afterwards that from the way it was said the registrar gave the impression that that was all she, the student, was able to manage. Not only was such statements

demeaning to the student but also they clearly placed the students at the very bottom in the status structure.

Summary

Some midwives did attempt to teach students when possible but were greatly hindered by their lack of understanding of student needs and teaching strategies. Despite this lack, many of them were quite creative in their efforts to assist students in learning skills which had a non-visual component.

Olesen and Whittaker (1968) suggest that student's complaints represent reactions to the tensions generated by the need to conform to programme requirements and inform us of constraints within the programme. In this study there were many constraints to students' learning and their opportunity to practice with increasing independence.

The fact that the educational staff rarely appeared in the clinical area emphasised for both clinical staff and students that they had little interest in the students' clinical progress. Lack of preparation in skills prior to being expected to perform them in the clinical area created a great deal of stress and anxiety in students particularly when they were performed in high risk areas, such as the labour ward.

Stress appeared to affect the students not only through their lack of preparation for skills but also because of its effect on the midwives. During this study, working conditions were quite difficult in some areas and there was an implicit expectation that students would replace a shortage of midwives. Midwives who were motivated to teach became quite frustrated by working conditions which did not allow time for reflection or debriefing of students. This frustration may have contributed to a significant turnover in staff which, in turn, compounded the students' problems with learning.

> Midwife "They want to decrease the staff to about 3 midwives. I don't know who will teach the students. Even now we are so busy I don't spend time with my student". (Week 5, antenatal clinic)

An eclectic approach has been taken in the approach to the limited data on learning. The theories of Boud et al (1985) and Schon (1988) have been evaluated for their contribution to an understanding of student learning styles. Deep and surface approaches to learning

hypothesised by Marton and Saljo (1976) provided some insight into how students may adapt to personal learning needs and the needs of the environment.

It has been suggested that if teachers do not pay attention to the effect of individual learning styles then student motivation may be affected (McMillan and Dwyer,1990). Students appeared able to retain motivation for the profession despite the difficulties they experienced with learning clinical skills. The fact that little attention was paid to students' learning styles by tutors and midwives would suggest that it was not necessarily the most significant factor in how much a student learned even though it may have improved the efficiency and depth.

What seems to be a significant factor is the number of midwives who can provide students with a positive feeling about their profession to the extent that they want to continue in midwifery even though they feel unsure of their skills. What is especially unfortunate is that most students demonstrated a high level of motivation which was not supported generally by the institution. It is also unfortunate that the midwifery personnel did not recognise the inefficiency of trial and error learning and its cost, not only to the institution but also to the midwifery profession.

CHAPTER SEVEN

THE ROLE OF THE STUDENT MIDWIFE

"Treat people as if they were what they ought to be and you help them to become what they are capable of being. "
Johann W. von Goethe

This chapter will discuss the socialisation of students to the midwifery role and the reduced student status as a major theme which emerged from the data. Another major idea to emerge was the difficulty of resocialisation from a career in nursing to that of midwifery. Research references from other disciplines will be used to validate these themes.

A literature review on socialisation to midwifery will not be presented in one piece because little has been done in this area. The only research on socialisation to midwifery has been carried out by Davies (1988) and this has been discussed in the succeeding chapters as it relates to specific properties of the themes which emerged from the data. References to midwifery training will not be presented because they are not research-based and do not provide an informative perspective on the data.

Before discussing some of the major themes emerging from the data it is important to identify the perspective within which I have functioned. The quotation above provides the basis for my perspective. It is often the way individuals are treated by others which guides their behaviour in certain ways and during specific situations. To extrapolate further, an individual's behaviour in a specific situation is guided by other people's expectations of one when that individual has been identified with that situation. In fact, the discussion here is concerned with how people behave when functioning in a specific role.

While recognising that the sought after ideal in grounded theory analysis is to creatively identify concepts which have the potential to form a theoretical framework, previously unrecognised, it is important not to ignore concepts previously acquired through one's own education and experience. Inevitably some of these concepts came to the forefront during latent analysis and insisted on remaining. Among the concepts to which I am referring are those that belong to a theoretical framework, known as Role Theory.

There has been a great deal of debate concerning the use of role theory for research studies. As a non-sociologist I cannot begin to debate its application with any expertise. However, given the nature of part of the data analysed and its propensity for identification with a general theoretical framework encompassing role, it is important that pertinent facts concerning role theory be discusssed and identified. Also, given the terminology in use in this text I do not wish the reader to be misled into believing that the theory of role has been applied to this data.

Part of the problem concerning role theory is that sociologists themselves cannot agree on how it should be used. Many are operating from different perspectives which often fail to recognise the value of other discourses. The problem of different perspectives can be seen by the fact that subscribers to the early literature on role identified its acquisition as a mainly passive process of socialisation. This process is generally referred to as the structural perspective of role theory. Subscribers to more recent literature perceive role acquisition as a largely interactive process where role players react to their socialisers' experiences in ways that reveal a mutual and reciprocal though not necessarily 'equal' influence. The 'interactionist perspective' derived its full name, symbolic interactionalism, from its insistence on a view of human behaviour as a response to the symbolic acts of others.The most recent literature recognises the usefulness of both approaches.

Conway (1988:64) espouses a combined approach when viewing role, with relative emphasis on symbolic interactionism. She argues that because roles are structured to 'fit' into specific positions, as required by the social situation, the structural perspective should be regarded as the 'skeleton' on which the actors can provide the flesh which will make their roles more explicit. In other words, the actors build upon and develop within their roles but from the structure provided, contracting and expanding their role as required by the situation, their personality, experiences and social interactions

Given the nature and complexity of the problems associated with the conceptualisation, let alone the application of role theory, briefly alluded to above, I want to state clearly that my application of the concepts is quite liberal. I am using the terms identified later in the text only because the data analysed has indicated the use of such terms, and not as part of a general application of the theory of role. An eclectic approach to the description of the data will be used which consists of the utilisation of terminology from role theory as if it consists of a set of tools to apply to data relating to behaviours and expectations.

7.0 Institutional Structure and Midwifery Role Function

There is a sound argument for the use of an eclectic approach in this study which brings together structural and interactive perspectives' contrast in focus upon the concepts of role, behaviour, norms, sanctions and status which can be used as units of analysis. One part of the argument is that a description of social structure is obviously necessary in any discussion of role. Social structure provides a guide for where to look when attempting a sociological explanation of the way in which, a student for example, behaves within the hospital environment (Coulson & Riddell, 1970). The study site had a structure which had to be taken into account when discussing the data. Such a structure provided the researcher with formally identified roles and responsibilities as they were documented in job descriptions.

In this study, the formalisation of a structure for the midwifery role was emphasised still further for staff and students through the provision of specific policies for patient care, in each of the maternity units. These policies, while identified as guidelines for the novice and the inexperienced practitioner, tended to be presented by 'management' in such a way that many midwives believe them to be 'law'. Management in effect did not disabuse the midwives of this notion because, for them, safety of the mother and child was paramount. It might be the belief that providing a rigid structure with little flexibility for independent action by midwives is the best way to ensure such safety. The administration's concern for reducing the risk of litigation as a result of midwife's actions was supported by the medical staff.

The influence of medical staff on midwives' effective functioning and perceptions of their role has been well documented (Campbell, 1989; Hicks, 1992; Robinson, 1989b). Kirkham (1987) noted in her study of midwives and the information which they provided to labouring women, that they were inhibited by medical staff in the amount of information

that they provided to these women on request. She also noted that in consultant units, medical policies inhibited midwives from providing the type of care that they would give to women they cared for in G.P. units or at home.

Medical personnel tend to perceive midwives in fairly rigid terms in that they expect them to passively perform discrete tasks in a manner specified by the unit policies. If midwives do not conform to this expectation and function in a more independent and less specific fashion, the medical staff become alarmed, feeling that such behaviour puts the mother and baby at risk of an unsafe outcome. As a result of this concern, medical staff support and formulate medical management policies which subsequently restrict independent action by midwives. Their concern is, that if midwives behave in an independent fashion by making their own decisions concerning the care of women, and the women suffer, the result may be litigation against the medical staff.

It was quite clear from my discussions with both the medical staff and the midwives that neither group had clearly identified the extent of the medical staff's responsiblity for the actions of the midwives. Some of the medical staff expressed the belief that any detrimental care given by midwives to their clients was a medical responsibility for which they could be sued. A minority of midwives also subscribed to this view. However, the majority did seem aware of the fact that they themselves were legally responsible for the care they gave and were 'covered' both by the Royal College of Midwives insurance scheme and that of the employing health authority.

It would appear that each group was functioning from a different perspective of midwifery practice. The medical staff promoted the organisational perspective of midwives working within specified policies. Midwives saw such 'medical' policies as necessary only for backup, for use if they ran into a situation which they felt they could not handle. Many midwives wished to behave in an independent fashion which utilised their own acquired strategies of assessment, analysis and decision-making in the care of their clients. While medical staff and the midwives often talked together about individual client care they rarely discussed their respective roles in that care. This lack of communication on aspects of role led to a diversity of expectations in the practice situation which served to emphasise the problems encountered when attempting to apply to qualitative data, anything other than the basic terminology of role theory.

The second part of the argument for an eclectic approach to the application of the concepts of role theory is that one cannot observe people within a social environment in an extended fashion without incorporating a symbolic interactionist perspective focusing on interactions in which the people actively construct their environment through a reflexive exchange of information. Those individuals have 'personality' and their prior experiences of life. While such biographies are not attributes studied in depth in this project it became very obvious from the data that students' previous experiences in nursing, at the very least, were important factors in their transition to the student status and the profession of midwifery.

7.1 Occupational Socialisation

Although there has been little research conducted on midwifery socialisation it may be helpful to discuss how socialisation occurs in other occupations and how it affects the inductees. Certainly it would appear that some aspects of the process in midwifery are similar to those in many occupations particularly in the outcome achieved by the organisation. Such an outcome is the type of person who closely adheres to the requirements of the institution.

Pavalko (1971) suggests that occupational socialisation along with the development of an occupational identity occur in two distinct settings, in formal classroom training and in actual job performance. These can occur prior to work in the profession but this depends somewhat on the length of the training programme and the clarity of the communicated expectations of recruits by others in the profession. Shorter training programmes offer less opportunity for this type of socialisation to be successful. Pavalko believes that in professional types of work socialisation that occurs during the training period is crucial in transmitting 'professional culture' and a professional self concept. However, there may be additional factors involved in nursing socialisation that are more important than the length of the training programme.

The establishment of nursing as a profession is said to rest on the professional socialisation of nurses. (Lynn, McCain & Boss, 1989). In an attempt to assess the socialising effects of a university setting, Lynn et al (1989) looked at the professional orientation and nursing performance of two types of nursing students over a five year period. A sample of 30 registered nurses who had entered an American university programme to obtain their degree was compared with a sample of 190 generic nursing students on professional

orientation scores and on a six dimension scale of nursing performance. Each group was assessed at entry into the programme and on exit. The results suggest that the registered nurses were significantly less professionally socialised than the generic students and their scores did not change between exit and entry. The generic students' scores changed significantly between the two assessments suggesting that faculty had a major influence on their professional image of themselves.

Unfortunately these authors gave little detail on the two programmes in terms of length and types of study. It is usual for registered nurses in baccalaureate programmes in North America to study for shorter periods than generic students and to obtain much less clinical experience because of their prior training. Therefore, one is unable to determine whether the differences between the two groups are the result of a shorter programme, the reduced amount of clinical training or the previous socialisation of the registered nurses. The authors concluded the latter was the explanation but this would appear a little simplistic. It is possible that the support role of their peers in this type of setting may have maintained their previous values and reduced the effect of faculty socialising influences (Davis, 1983).

One can draw some parallels between Van Maanen's (1973) ethnographic study of the induction of police officers from their training period to their first 'street experience' and the induction of student nurses and midwives in training. Van Maanen describes the process recruits go through in order to be accepted into the police academy. As a full participant in the three month academy training programme he was able to identify the efforts made by the institution to 'homogenise' the recruits so that they were socially engineered into the type that the institution wanted.

Initially the recruits were 'wooed' by the police administration. The department set out to impress the potential recruit with the elitism of the organisation in an effort to elicit some commitment to the occupation prior to entry. This impression enhanced the recruit's self esteem and supported his conviction that he had made the right choice in occupation. This form of anticipatory socialisation was often further bolstered by a friend who had recruited the individual.

Policemen, like nurses and midwives, chose their occupation because of a sense of commitment and interest in serving the community (Simpson, 1979, Van Maanen, 1972). It is possible that like nurses and midwives they also saw participation in such a role as

improving their own self image. Like nurses they entered a reality that appeared very different from their idealised notion of what their work would entail (Simpson, 1979; Davis, 1983). For the police recruits a different reality was provided upon entry to the academy where, having believed they had survived the worst and were now accepted by the department, they were abruptly informed that they could be cut off at any time throughout their probationary period without the right of appeal. In addition the academy provided a harsh and often arbitrary discipline coupled with a demand for total obedience.

In this sense police socialisation was very much like that provided by the military. Academic demands of professional soldiers were of rote learning and coping with a rigid, detailed daily schedule which allowed no room for creative thinking and problem solving (Pavalko, 1971). Davis (1983) quoting Janowitz (1971) describes how the imposed 'homogenising' of recruits through the requirement of short hair cuts, uniforms and rigid disciplinary action for minor infringements of army regulations, was used by the military to ensure the recruit made a rapid transition from the individuality and freedom enjoyed as a civilian to the non-questioning obedience of the soldier.

There are some similarities between military and police socialisation and the socialisation of midwives. Midwifery students in this study also tended to be 'wooed' by the education department upon their application and entry into midwifery. In the initial few weeks, in contrast to those experienced by the police and soldiers, education staff were supportive and enhanced the students' self image, giving them a conviction that they had selected the appropriate profession. The reality for the students occurred when they entered the clinical environment where there was little support for their image of themselves and a definite attempt to reduce the status of their previous role as nurses.

The police recruit was introduced to the realities of 'the street' by a field training officer (FTO) who acted as a buffer between him and the 'real work' of his occupation. In contrast to the academy teachers the patrolmen on the street were supportive of the new recruits and provided them with a warm welcome. There was no rejection of the recruits but there was a general dismissal of the theoretical component of their training. This was referred to as something everyone had to do in order to gain access to the occupation but it bore little relevance to the 'real world' of policing (Van Maanen, 1973).

When student midwives entered the clinical area they were no longer supported by the education staff nor were they warmly welcomed by the midwives in the area. As

mentioned earlier, a mentor system was in place which would have resembled that of the FTO for the police recruit if it had been functioning. The time spent with the community midwife did afford this form of one-to-one teaching and supportive function and was popular with the students for these reasons. Van Maanen (1973) felt that patrolman training patrolman ensured continuity of training and socialisation separate from that provided by the academy. However, he was discussing a supportive experiential training where the expectations of the department and 'the street' were clearly and openly communicated to the recruits by the FTO's. For the midwifery students the community was the only clinical area where similar teaching and support were present; for the other clinical areas 'reality' was much more stressful. Communication was restricted in many instances and student midwives were able to identify expectations only after they had contravened them. Examples of this will be provided later in the text.

Midwives were rarely observed to communicate to students the expectations of the profession but did undertake to train them to the technical and task requirements of the department or ward in which they worked. Such endeavours produced students who were 'safe' to be left with clients and able to 'do the work'. Training all students to the same level of technical expertise without the benefit of creative problem-solving strategies is more indicative of occupational rather than professional socialisation. This has been clearly identified as the process in military and police socialisation (Davis, 1983). Like Van Maanen's police recruits these student midwives learned to be passive and not to question decisions.

The process of taking new recruits and making them all behave in the same fashion has been referred to as 'homogenisation' (Davis, 1983). This is undertaken by an institution in an endeavour to remove previous socialisation or at the very least to reduce its effect on the present socialisation process. Pavalko (1971) suggests that in adult socialisation there has to be an 'unlearning' of old norms and roles in order to take on the new. This is often the situation when the expectations of new roles conflict with expectations already held for the old. An example which he provides is that of the military where the 'freedom' of the civilian role conflicts quite sharply with the subordinate role of the soldier. Unlearning of an old role may be required by the student midwife who encounters conflict between her previous nursing role with its illness orientation and higher status and that of the student midwife's role with its healthy focus and reduced status. A factor which may contribute to this conflict was the tendency for midwives in this study to suggest that the student's previous nursing role has no validity in their new career.

Other forms of 'homogenising' of student midwives were observed on the study site. Uniforms were required which were different to those worn by the midwifery staff and students were treated the same by the ward staff regardless of their level of expertise, training and prior experiences. As noted later in the text some midwifery sisters would refer to the students as 'nurse' and few took the trouble to learn their names. Any deviation by the student from what the midwife saw as the student's appropriate subordinate role was treated with social sanctions. These included a refusal to communicate with the student until she had learned the 'error of her ways'.

Pavalko (1971) suggests that individuals often submit to institutional socialisation in order to get something in return, such as access to an occupation. Simpson (1979) found that student nurses who entered training with a desire to help others soon experienced a shift from humanitarian concerns to concerns with the mastery of skills. This shift was the result of the emphasis placed by the educators and the institution on work related needs. In this study it was clear that for some students a great deal of indivuality was sacrificed and the the process of 'homogenisation' left them questioning whether they wanted to continue in the profession.

7.2 Socialisation of Students

One of the strengths of role theory is the capacity to juxtapose different concepts, such as socialisation, negotiation, power and control. Socialisation is a social process vital for sustaining a social system whereby an individual acquires essential knowledge, skills, dispositions, behaviours and the motivation to participate effectively in social groups. The outcome of sucessful socialisation, in a structuralist perspective on midwifery, would be the acquisition of appropriate technical and social competences and a motivation to stay in the profession (Cohen, 1981; Cottrell & Cottrell, 1969; Smith, 1968). The acquisition of such motivation to participate in the system and to conform to the norms identified for a specific role, might be regarded as the intended outcome of those who 'plan' or 'control' such socialisation practices.

'Failure' of such socialisation could be inferred as one of the causes of retention-failure when one reviews the figures of practising midwives in Britain. Only one-fifth of those trained in midwifery continue to practise after qualification (Kaufman and Renfrew, 1988). However, failure in motivation would be more than a little simplistic if taken as the heart

of such an explanation. Rogers (1986) suggests that the cause of poor retention rates in midwifery is due to a less than rational approach to training. While the cause of poor retention rates is clearly multifactorial, a less than rational approach to the training of midwives has been identified as one more important element from the data in this study.

Symbolic interactionism suggests that individuals negotiate their own interpretation of social order. Formal rules and obligations may be changed or modified as a result of negotiation during interaction (Hardy & Hardy, 1988).On this case study site, students in the junior period rarely attempted to negotiate with the midwives, probably because of the perceived weakness of their position due to their lack of knowledge and status. It became apparent that their newly-reduced status from staff nurse to student, resulted in many of them suffering from a lowered self esteem. A poor self esteem could be assumed frequently from their verbal expressions of anger and discontent with the system and its failure to recognise their worth in their previous role. A low self esteem could more than likely affect their confidence in their negotiating ability.

> Janet "You know you've been qualified for so long and running a ward and everything, and this was like the real lowest of the low and it was annoying that people didn't know your name or refer to you by name".(Week 52, Set B, qualified 2 months, interview)

The increasing knowledge of the more senior students equated with an increase in their confidence concerning their functioning as midwives. Such confidence in the 'rightness' of their position vis-a-vis the appropriate functioning of the midwife, led some of them to challenge midwives who practised within the medical model. The sets of students differed considerably in how many of them would challenge the midwives and how many were less confrontational. The most senior set, Set A, was split fairly equally with those who were more inclined toward peaceful negotiation and had a perception of their colleagues as 'troublemakers'. The two most recent 'sets' contained few students who appeared confrontational but this may have been the result of their recent drop in status to student.

Whether or not success in negotiation was achieved for the senior students appeared also to be a function of the confidence of the midwife with whom the student was negotiating rather than with whether the outcome was justified. A midwife confident in her clinical skills did not seek to control the student to the extent evident in those with less confidence in their practice. Confident midwives allowed students to be successful in negotiation but

often such results would be overturned by a second, less confident member of staff on the next shift. As a result, the majority of such negotiations could not be considered by the students to have a permanent outcome. This was unfortunate, because positive role negotiations and permanent changes in outcome provided students with increased self esteem and job satisfaction and appeared to be a motivating influence on their professional orientation.

> Bronwen "Sister X was great (community midwife), she's into herbal remedies. I think I've learnt more from that one person than any other person in any place. I was treated more as an equal. She let me get on with it. We'd do half the clinic each. I'm definitely staying in midwifery---here for a while".(Week 31, Set B, trained 15 months, labour ward)

Midwives may be considered, like nurses, to belong to the semi-professions in that their work is controlled by others in an administrative hierarchy. This form of supervision and evaluation by others is not part of the professional's world. It has been suggested that professionals, such as those in medicine, have a stronger identity with their profession as a result of their extensive socialisation period which can range from four to six years (Hardy & Hardy, 1988). In comparison, the majority of midwives undertake an eighteen month training, after a three year socialisation period to nursing, and this often ends with the majority of midwives opting out of midwifery at the end of their training (Rogers, 1986).

7.3 Students Selection for Midwifery

Professional socialisation has many stages. First, there is the selection of students with putatively desirable attributes who are considered to have the potential to become a midwife. What those attributes are thought to be is never formally stated and appeared on interview to vary slightly from tutor to tutor, dependent on how 'conservative' or 'radical' their views were on midwifery. The 'conservative' tutors appeared, not always consciously, to identify many 'nursing' attributes as important for prospective midwives to possess. In contrast, those considered to have more 'radical' views identified attributes, such as assertiveness and a questioning, challenging approach. Such attributes tend to be antithetical to traditional educational approaches in nursing and midwifery.

On admission to a school of midwifery, students are provided in the classroom with a legal definition and a description of the role of the midwife. The theoretical presentation consists partially of the Education Department's concept of the midwife's role within that

specific institution, but principally draws on the structure provided by the United Kingdom Central Council and the E.C. Directives. While the documented role definition is helpful as a base for the students, internalisation requires an experiential component from the practice area (Schon, 1988). Many student midwives referred to such an experiential process as 'trial and error' learning.

The main repository of midwifery culture is the Education Department where the course content was taught in modules quite unlike the experiential exposure the student received from the clinical area. However, an attempt had been made to combine the two but this was not always successful. The staff in the Education Department viewed the students as 'professionals in the making'. This perception tended to conflict with that of staff in the clinical area where they were seen as just 'another pair of hands' with which to provide service and thus relieve the midwives of some of their numerous tasks.

In viewing socialisation from a nursing perspective, Simpson (1979) includes the development of technical abilities as part of the socialisation process, with nursing education as the primary socialiser. While the dissemination of professional knowledge was considered to be a major part of their role, the development of technical abilities was not perceived by the Education Department to be their responsibility. As mentioned earlier, the integration of professional knowledge and technical skills was usually left to the midwife. The midwife was often recently qualified and rarely able to integrate the concepts to the degree required by the students. Many students identified this as a problem which they perceived to be the fault of the Education Department because they were the 'ones who knew how to teach.'

Olesen and Whittaker (1968) refer to the same dimensions of socialisation as developmental and place less emphasis on the role of education. They recognise that there should be sufficient cognitive preparation for an individual to perform a professional health role but suggest that it is the orientation of the individual which enables them to perceive the demands of the role and so provide the required behavioural activity. They also believe that an individual requires motivation to make the transistion from one situation to another. I am unable to support or deny 'orientation' as a factor in socialisation with my data but it has a certain logic which is difficult to deny without further evidence. However, I do believe my data indicates that motivation of the socialiser as well as the socialisee is a key factor in the successful transition to the role of the midwife, especially with regard to orientation of the student to the profession.

7.4 Role Models or Mentors

During each clinical placement, the students engage in activities which attempt to model those of the midwife in practice. In observing the duties and skills of the midwife as she practices her definition of her role, student learning is inextricably linked with what is observed and the rewards received for demonstrating the appropriate behaviour. Each midwife practices according to her own perception of the role which may be a narrow or an expanded version of midwifery. The student observes the midwife's practice and compares it with the definition provided by the midwifery educators. If the midwife's practice was limited to the medical model, it caused conflict in the student due to incongruence with the definition provided by the Education Department. Conflict rarely occurred when the midwife practised an expanded form of midwifery. If it did, the complaint by the student was that the midwife was behaving 'like a doctor'.

How the student reacted to the midwife's practice of her role depended in a large part on the cognitive interpretation of role provided by the school. The interpretation provided at this study site rarely favoured the role practised by the midwife because it provided the students with an idealistic interpretation that was often difficult to perform within the present maternity environment. When incongruence occurred it led some students to reject the version observed in the clinical setting while others rejected the version provided by the school. A few attempted to combine the two approaches. Such coping strategies were noted by Kramer, as long ago as 1974, who found the same strategies used by degree nurses attempting to adapt to a new, organisational work environment which tended to de-emphasise the professional aspect of the nursing role.

> Ida "We all know exactly what our role is but we just practise according to where we work".(Week 56, Set B, qualified 3 months, postnatal ward)

In the early stages of training, the different interpretations of midwifery provided by education and service could often lead to an exacerbation of role ambiguity in the student. Ambiguity for midwifery students was already a major problem in the early stages of training because of their previous nursing role which they had not, as yet, discarded. As a result, many of the junior students felt unequal to the task of identifying for themselves which interpretation of midwifery, education or service, was the most appropriate. Such

an intepretation was not helped by the fact that many of the midwives supervising students were not comfortable with their own skills.

> Merril "Lots of time was spent with midwives who felt insecure if they're not doing it (performing the skill). They see themselves as, 'the midwife' and therefore 'I should do it'". (Week 9, Set A, trained 17 months, labour ward)

While many senior students felt an affinity with education because it treated them as budding professionals, the junior students were too recently removed from the service perspective in nursing to obtain much objectivity with regard to a midwifery perspective.

The student's commitment to the midwifery profession was, to a certain degree, affected by the midwives' attitudes. This was clearly emphasised by the senior students if the midwife functioned within the medical model of care provision. Fiona complained about the midwives who she felt were less than professional in their dealing with the clients in the antenatal clinic,

> "There's pressure on all the time to do the bookings and get the doctor started. Got the impression they (midwives) are just not interested. Only want to work 9-5 and talk about their lifestyles while we do the bookings". (Week 7, Set C, trained 6 months,)

While criticisms such as this were perceived as strategies by students to reduce conflict within themselves, they also served another function. They helped the student to redress the balance of power between herself and the midwife. Criticism of the midwife's lack of professionalism helped the students to place themselves in a more favourable light in their own eyes which added a sense of power not previously apparent to their self perceptions. Such strategies would also appear to be part of the developmental process required for occupational commitment although this could be misleading. Some students who complained did so because of anger with the system which diminished them. When interviewed these students indicated clearly they would not practise as midwives once their training was completed.

> Janet "I found it awful when I first came here (antenatal clinic), I wanted to leave the next day. Some of my set never want to come back. They don't want to stay in midwifery. I'm not sure if I will". (Week 7, Set B, trained 10 months, antenatal clinic)

Whenever a complaint was made about midwives it rarely included the community midwives and was nearly always aimed at the hospital staff. This was probably because, as many of the students indicated, the community midwife was the only person who truly fulfilled the role of the midwife. It was certainly made clear to the students in the early part of their training by the Education Department that the community midwife was more representative of midwifery because she provided continuity of care. This was emphasised in the fact that students spent their first clinical practicum in the community.

Continuity of care in midwifery is rarely provided in hospitals unless team midwifery is in place. As discussed earlier care tends to be fragmented down to mini-specialisations, such as antenatal care, postnatal care, labour and delivery. Midwives who were perceived to be supportive of such fragmentation were often identified as poor professional role models. Such negative perceptions will obviously have an effect on a student's motivation to be midwife.

> Jodie "Did a booking today. Frankly, I wouldn't have done it if I'd been with the midwife I was with yesterday. I feel more at ease with Janet (set B)---less rushed. She is so positive. Leapt at the chance to do a booking. I'm not idealistic but Janet did it the way we'd been shown" (by the midwifery teachers). (Week 6, Set D trained 2 weeks, antenatal clinic)

Midwives who were perceived as not fulfilling the role identified by the student were often singled out by them for complaint. Fiona was a student entering the middle period of her training who tended to be positive about her experiences. But even she felt moved to comment generally on the midwives and their role performance. Given her comments, one could only assume that the criteria she was applying to the midwife's role did not come from the clinical area.

> "I don't think they're fulfilling their role. I think midwives are losing a lot of their skills partly because of the use of technology---sometimes necessary, sometimes unnecessary. Its like discharging patients--clients and their babies. Its been done by doctors in the past, I mean community midwives discharge their own patients. It's within the midwife's role to do that and yet it's been done by medical staff up to this. The doctors seeing all the patients in the antenatal clinic----there are examples like that where we're not fulfilling our role". (Week 18, Set C, trained 26 weeks, antenatal clinic)

A major prerequisite for learning a new role is the development of the capacity to take on the role of the 'other' in an interaction. The manner in which the 'other' shapes enactment of the role depends on the individual's perception of the 'other' and on whether the the role-taking is reflexive or non-reflexive (Turner, 1956 :319). The individual, in this case the student, may adopt the 'other' or the midwife's perception of the role, resulting in her own identification with the role. This is, of course, the whole essence of professional socialisation but in some situations it does not occur. Whether it occurs may depend on how the student values the midwife's interpretation of her role. The value the student places on the midwife's interpretation will be guided by how much she accepts the values identified for her by the Education Department.

Many midwives recognised the role of education in providing definitions for role performance even though a few complained about the 'idealism' of the interpretation. They also appeared to recognise that role models were necessary for students. What they seemed to fail to recognise was the fact that the consistency of the modeling was a necessity particularly in the junior period, when the student had not had the opportunity to formulate a clear idea of the role.

> Susan "It's according to different mentors (role)---different things. On the labour ward my mentor made sure I could cope before letting me get on with it. But a lot of the other mentors just left me, for example in the clinic she often had to leave me in one room and she used to ask the doctors to assist in teaching me". (Week 56, Set D, interview)

It is possible that the lack of consistency in role models during the junior period affected the reflexive aspect of role-taking. Students may have become non-reflexive in their role

aspirations, manipulating the image of themselves in order to 'fit in' with the required behaviours. Perhaps this was the situation for students who demonstrated the required behaviour of a midwife but left midwifery when their course was finished. Given that my sample consisted only of students still training and those recently qualified but still working in the hospital, this was not area I was able to address but is a question worth considering.

7.5 Status Identification.

Appropriate status identification has been referred to as occupational self-image by Huntington (1957), as public identity by Becker (1963) and as professional self-concept by Kadushin (1969). When or how student midwives acquire a midwifery identity is not an easy knot to unravel. Many appear to have anticipated the role prior to their entry into the programme, probably through the short period of time spent in obstetrics during their nursing training. Whether one could call that 'early socialisation', when the role is not the same as that for a student midwife, is an interesting question. It is almost certainly another factor which creates problems when the student enters midwifery because it tends to provide unreal expectations.

> Merril "My expectations were shattered. I think they were a bit high to begin with but I found the programme an endurance test. I was shocked by what happened on the labour ward. I expected things to be much more natural. I don't think I've learned how to be a midwife". (Week 8, Set A, trained 16 months, interview)

Another student who also had a problem with prior expectations was little more accepting of her differences.

> Mabel "Oh, the programme's alright, but different from what I expected—more technical. I didn't expect that". (Week 10, Set D, trained 6 weeks, labour ward)

Some students quite clearly viewed themselves as midwives and resented other people referring to them as nurses. On the labour ward students were nearly always called nurse and some of the sisters there would refer to other midwives as nurses.

> First sister to Florence "Nurse, we are going to put a drip up on her when she's been to the toilet."
> Second sister to Jodie " Could you check the baby with nurse (midwife) before you get your book signed". (Week 8, Set D trained 4 weeks, labour ward)

Some students complained that the above type of behaviour irritated them because they saw themselves as fledging midwives and felt that for midwives to be called nurse detracted from their perception of themselves and reduced their own professional identity as well as that of the midwives themselves. Many pointed to the fact that most of the women and their husbands, despite long exposure to midwives in the antenatal period, still referred to their midwives as nurses, in the labour ward. However, the 'nurse' label did not seem to be quite so evident on the postnatal wards or in the antenatal clinics.

A few students thought there was nothing derogatory in the use of such a title and felt that such usage was preferable to other things they had been called.

> Ginny "I don't mind people calling me a nurse because I am a nurse but I think other terms in front of the patients are very unprofessional and as students we are referred to as all sorts of things ----- you know, 'slave' and other terrible things. It's all very condescending and insulting because you know you are doing your best and I don't think that atmosphere is very conducive to learning".(Week 31, Set B, trained 15 months, interview)

The acceptance of the title of nurse by some and not others seemed to be partially related to whether or not other derogatory terms had been used in their presence. The use of derogatory terms was not a complaint from all students and related more to individual midwives than to a wholesale derogatory perception of students by other practitioners. I suspect that the confidence of the midwives in their practice played a major part in their perception and treatment of the students.

One particular sister was famous throughout the hospital for calling everyone nurse and was generally regarded by the students as a poor role model for midwifery. Whether in fact, this was anything to do with her use of the title 'nurse' or whether it was a feature of her behaviour as a midwife was not clearly identified by students. However, personal observation would lead me toward the latter explanation because her behaviours rarely

demonstrated a midwife functioning within an expanded role, making decisions concerning patient care independent of the medical staff.

The use of the term 'nurse' when referring to midwives reflects a conflict within the profession as a whole. Many midwives felt that the use of the title 'nurse' indicated that midwifery was an extension of nursing and for this reason such usage was deemed counterproductive to a professional midwifery image. Other midwives saw nothing wrong with identifying with their nursing background to the extent that one researcher called her thesis, *Midwifery: the happy end of nursing* (Davies, 1988).

One student clearly believed that her group of students may have been doomed from the start with regard to the socialisation process because they appeared not to have had any of the anticipated motivation for the midwifery role prior to their entrance into training.

> Mandy "I think the majority of our class are here not because they like midwifery but because they hate general (nursing) and want to be studying again". (Week 18, Set C, trained 22 weeks, postnatal ward)

We may well have here a more common factor than previously recognised in the literature determining the failure to motivate many students to go on to practice midwifery. In the current climate of change in the health service some nurses may use midwifery as an escape route only to find that it is an aspect of health care which does not after all hold an attraction. For others, faced with the prospect of unemployment, it provides an additional training while continuing the salary they have received in the past. Whether one ought to refer to it as a lack of commitment (failure to practice after qualification) to the profession, a failure of socialisation is however, debatable given all these complicating factors. What one could question however, is the adequacy of the criteria used by midwifery teachers in assessing the motives of applicants for such training.

Status identification is not a simple reflection of actual attainment of professional practice but evolves through transactional processess the nature of which can be conceptualised in different ways. The midwife can assist or retard identification by the way she role models for the student and how she supports her profession through such modelling. Reducing a student's anxiety through closer supervision can only assist with a student's learning and

consequently her identification with midwifery. Florence's earliest experiences on the labour ward were not designed to help her with either task.

> Florence "That first day I felt I was locked in this room—like a cell. I was quite shocked. I found it all a bit threatening. I had to remind myself that I had qualifications". (registered nurse) (Week 9, Set D, trained 4 weeks, labour ward)

Midwives themselves often have contrasting ideas with regard to how students acquire their concept of the midwifery role. Such a contrast was evident in the ideas expressed to me by two midwifery sisters when I asked them how students acquired the role.

> Sister A "I think the idea of the role comes from the school. I think that its clarified there fairly early on". (Labour ward)

> SisterB "By practising it---a lot---they should get experience, you know, like deliveries or whatever, guthries, you know, things like that and just practising and hopefully from the midwife's teaching". (Postnatal ward)

In contrast to the sisters' points of view was that of Joanne who had only three months left to complete her training.

> Joanne "I think you only learn the role when you're qualified. I think you have a certain idea but there's an awful lot you don't realise as a student which you find out later which I think you should be taught as a student. (Week 3, Set A, interview)

This type of conflict in perceptions of role between midwives and students was common whether it related to how one acquired the role, the extent of the role or to the practice and function of students within the role and within the service area. One of the problems, discussed earlier in Chapter Five, was the fact that students were given no responsibility until they were actually qualified at which time they were expected to switch completely and 'behave like midwives' assuming those responsibilities. Such a drastic change in the level of reponsibility was almost too much for many of the students on qualification.

The two views expressed above support the conflicting socialisation perspectives identified in the studies by Becker et al (1961) and Merton (1957). In Becker's study medical students did not take on the professional role until after qualification largely because the training system would not allow them the responsibility. The converse was true in Merton's study where medical students were treated as junior professionals and given such responsibility. However, it must be stated that the two studies did measure different aspects of socialisation and reality. Merton's study was qualitative using observations and interviews to assess reality while Becker used questionnaires which relied on student perceptions and recall. In addition the two medical schools had different types of training programmes which would lead to different outcomes. Despite this the information provided by these studies is valuable in that it alerts the researcher to the complexities of socialisation and the caution which must be used in generalising the outcome to other settings.

7.6 Difficulties with Role Transition.

The move from student to midwife created differences which were reversed in the move from staff nurse to student. The difficulties began at entry into midwifery, with the reduction in status from staff nurse to student, a difficulty for individuals already socialised to nursing. Previous nursing experience and registration has been identified as interfering with the fit between the new midwifery role and the prior role of nursing (Davies, 1988). Benner (1984) found that student nurses, saw themselves as experts in their previous area of work and the notion of starting as a novice or being perceived in that way was not considered acceptable. Support in this study for what Benner found was reflected in comments, such as the one made by Myrtle,

> " — they forget that you're a qualified member of staff and they just see you as a student again, especially the more senior ones, and I just feel it's a bit patronising". (Week 2, Set B, trained 9 months)

It appears that the students did not expect to be treated as students once they had achieved a status in another profession. Although it was not clear what work roles Benner's subjects had previously had it was clear it was not that of nursing. If these students, many of whom were straight from school, saw themselves as experts in other areas how much more difficult it must be for students who can actually claim such a distinction in nursing.

Jackie, who was in the second half of her training by the time I interviewed her, complained of being treated as a menial. She felt that such treatment really emphasised the reduced status of the student, decreased one's confidence and was, she implied, the usual treatment of midwifery students.

> "Sometimes you feel insulted in the way you're addressed but usually you get used to it. But definitely you feel less confident in your capabilities. You feel that everything you've learnt so far is of no use to you. It's just certain things they want done and there are other staff around but they just seem to say, 'Oh let the student do it'. Usually quite menial tasks and you're the one picked to do it". (Week 56, Set E, trained 11 months, interview)

How well the students were able to 'fit in' in the clinical area at the beginning of the course set the scene for their future placements and therefore was a source of great anxiety. How much nursing socialisation interferes with the 'fit' appeared to be a function of the coping strategies used by the students during the transition phase to midwifery. One strategy used by some of the students during their junior period was the threat to leave if the training did not go well.

It is somewhat surprising that, given some anticipatory socialisation to the role of the midwife, as well as their prior experiences as nursing students, that midwifery students suffered such an identity crisis. It is particularly surprising because most of the midwifery teachers, when interviewing prospective students, emphasised status transition as a problem. The vast majority of the interviewees claimed to be aware of the problem and seemed to feel they have prepared themselves for such an eventuality.

7.7 Education vs Service Socialization

Part of the process that seemed to occur initially with the students was what Merton (1957) described as the induction approach to socialisation. In this process the students were 'inducted' into the midwifery role by faculty and to a certain extent by the service staff. The forms of induction undertaken by education and service are very different though it is universally agreed that they should be complementary. The fact that they did not appear to be so would suggest a problem in communication between the two groups.

The process of induction of students by the education staff could be characterised as requiring a fairly passive assimilation of ideas relating to role (Olesen & Whittaker, 1968), while induction by the service area was perceived to be a little more interactive with the students being addressed to the values of their profession along with the physical performance of the required skills. The 'activity' of the service role appears in design terms to build upon assimilating ideas from the education staff. However, the reverse appears to have occurred. The education staff demanded more interaction from the students through processes like self-directed learning and reflection on practice. The service side, in contrast, appeared to expect students to be more passive and compliant in their acquisition of the role. The interactive component developed in the students by the education staff was often perceived by the service side as confrontational when students questioned midwives' practice. The active socialisation brought about through the interaction of students in the clinical area was not encouraged by the service staff. Indeed interaction was actively discouraged and in order to achieve this communication was reduced to the smallest denominator. Communication will be discussed in detail in Chapter Nine.

The fact that the Education Department and the service side had different criteria for role performance by midwives was quickly identified by students. Many students expressed frustration that the two sides could not 'get their act together' as identified by the following midwife in an interview.

> Ida "There seems very little communication between hospital staff and teaching staff. I think the hospital and the school have got to get it together. They're almost like enemies. People do things on the wards, like not letting students leave early, to keep the school happy. Its like, we don't want the school on our backs". (Week 52, Set B, qualified 2 months)

The identification of the education department as the organisation which would be 'upset' if the students were to leave the wards early, was an interesting phenomenon. The Education Department strongly supported the idea that if students had little to do on the wards, they could leave early and use the time to study. It would appear that the service staff were misleading the students concerning the philosophy of the educators in order to keep the students on the ward until it was time for them to leave. The midwives' bureaucratic approach to students and their work had no clear rationale for the students. It

is possible that its roots lay in envy of the student who had the freedom to come and go, with little of the responsibility carried by the midwives. This lack of responsiblity meant that students could leave while the midwives had to remain on the ward until the change of shift brought other midwives to relieve them.

The Education Department identified itself with the expanded role of the midwife who makes decisions about care, independent of the medical profession. The service side viewed the educational approach as unrealistic because of policy restrictions and personnel shortages. Service managers believed that these two factors alone place restrictions on the independence of midwifery functioning. A marrying of the two approaches involving expansion of the midwife's role within realistic parameters, would appear to be more in line with the professional image espoused by the United Kingdom Central Council. Unfortunately, while education appears to recognise the problems of service and vice versa, neither side seems able to provide a solution. Both appear to be believe their perception of midwifery practice is correct.

Although incongruence of perception between service and education may be a factor in the 'failure of socialisation' of some students, it is not logical to exclude the attributes of the inductee from the process of socialisation. Students are not inanimate objects passively taking on the values perceived and provided by the midwives. There are interactions between the students' personalities, values, previous experiences and the perceptions of their role which they take from education and from service role models.

A factor which could affect the student's perception of the midwife's role was one that midwifery educators did not appear to recognise as a possible problem. This was the use of obstetricians to teach midwifery content to students. The rationale for such teaching was that it constituted or consisted of 'abnormal obstetrics' as opposed to 'normal midwifery' and was therefore, not within the expertise of midwives for teaching to students. This was a valid argument if accepted at face value. However, the midwifery teacher's expectations, although not explicit, appeared to be that the obstetrician would teach the midwife's role in this area. This was not forthcoming in the form anticipated. The obstetricians taught the midwifery students what they knew about the care provided by the medical profession for women experiencing an abnormal pregnancy or labour. The care provided by the midwife and her responsibility for that care was often left by the midwifery teacher to the student's own interpretation.

There were frequent complaints from the students about the content of the classes taught by obstetricians. While vague guidelines concerning the content required were given verbally by the teachers to the obstetricians, these were rarely committed to paper. Many of the students complained that some of the lectures were 'above their heads' with the result that they acquired little useful information. However, a few students believed the fault lay with themselves and their lack of understanding. They perceived the lecturers to be extremely intelligent which they believed was demonstrated by their use of complex terminology when teaching. Many students appeared to equate intelligence with the use of complex terminology, and intelligence and terminology with good teaching. Therefore, they felt that any fault with acquisition of knowledge from such people lay with themselves. Such students appeared to obtain a reflected glory from the fact that these people had lectured to them even though they had learned little as a result.

7.8 Failure in Professional Identification?

Mandy, in the senior period of her training was thinking of leaving midwifery. She would be regarded by some as the product of a system which failed to provide adequate socialisation to the profession. However, she identified her desire to leave with the fact that she enjoyed caring for people who needed her. Skills required to care for those who were sick were the skills she enjoyed using, and were not required in midwifery.

> Mandy "I really enjoyed the course and learned a lot but I miss looking after sick people. I thought midwifery might be for me. So many people I knew had recommended it. I mean it's been really good especially for learning about the female psyche. I knew coming into it I wasn't likely to stay". (Week 32, Set C, trained 9 months, special care baby unit)

As Mandy pointed out she had come into midwifery already well-socialised to nursing, and although she was willing to give midwifery a try, she had never changed from her desire to be needed. She felt that while she enjoyed midwifery she preferred to care for someone who required her skills and her presence.

> Mandy "I don't feel I'm needed here. I mean a woman can go into labour and have a baby by herself—it's not advisable but she can". (Week 32, Set C, trained 9 months, special care baby unit)

One could argue that the situation identified above is the outcome of a lack of identification with midwifery. However, one could also argue that this type of student reflects a personality who selects an occupation, such as nursing because of an subconscious desire to be needed. One cannot however, ignore career motivation as a factor in someone entering an occupation in which they have little prior investment. If the profession has been chosen in order to promote a career in nursing or health visiting, then occupational socialisation is likely to fail. Alternatively, if midwifery has been chosen because of dissatisfaction with nursing then socialisation may be successful. Motivation is a factor which appears to play a significant part in the success of socialisation to midwifery and is also a factor which many new students have trouble retaining.

> Ginny "I feel quite disappointed actually, with the course. Not really the tutors or the course, but I think I expected better and I'm so disappointed I don't want to stay. I haven't exactly been ecstatic since I came but I stuck it out. I've applied to gyne". (gynecology course) (Week 26, Set B, trained 15 months, antenatal ward)

A midwife who had recently completed her training said that on looking back she had enjoyed her training.

> Linda "There were times when I could have chucked it in, quite happily. Like when I first started it was tough going back to the situation of being a student again. The school of midwifery was very helpful, backed me up all the way". (Week 28, Set A, qualified 18 weeks, interview)

It would appear that in the above situation the Education Department had sustained the student through periods of poor motivation initiated by negative role models in the clinical area. However, this student was also one that conformed more with role of the midwife as presented by the school than that expressed by the service staff. As a result she had experienced conflict with some practitioners when she had challenged their behaviour in certain clinical situations.

June had had a different perspective from many of her colleagues. She was anticipating working in the third world where she would receive little assistance from technology or the medical profession. As a result, her objective was to learn as much as she could about the extended role of the midwife in order to function competently in deprived areas. She

obtained permission to work in the labour ward to build on her experience in midwifery and extend the midwife's role with medical assistance. She left after several months to work in an isolated section of a third world country.

It may be a situation peculiar to the U.K. health care system that a nurse can embark on a career change with little financial cost to herself. Although classified once again as a student with the accompanying status of such a position, the nurse will continue to be paid the same salary she received while in charge of a ward. This could also be a factor in the difficulty many nurses experience when taking on student status. Such a factor could play a part in limiting the commitment required from an individual to undertake a change in career, such as that required for midwifery. If such a change involves little financial cost on the part of the nurse then it can be made without the same prior commitment to a new career that would be necessary if economic planning was required and hardship was the result.

Whether one subscribes to the idea that it is the success or failure of professional socialisation, which produces an individual who is or is not motivated to the profession, is one issue. What factors are involved in the process of socialisation is another. If one accepts failure of socialisation as one of the causes for a lack of professional identification, then one is accepting that socialisation is a passive, unidirectional assimilation and acceptance of values and attitudes provided by the socializer. However, the very nature of the profession of midwifery requires an interactive approach because of its emphasis on social exchange. Therefore, socialisation can be considered as only one of the factors involved in creating a professional identification in the individual. As mentioned earlier, the learning environment and the learning process are others along with communication.

One cause for the failure of role identification may be the heavy emphasis placed by the institution on structural features, such as policies which restrict the role of the midwife and its interactional aspects. Midwives have been found to be very unhappy and dissatisfied with restrictions placed upon them by hospital policies and the medical profession (Robinson et al, 1983). It is probable that this dissatisfaction is reflected in the midwife's work with students and may hinder the students from identifying positively with the profession. Dissatisfaction with the restrictions on midwifery practice has formed the basis for the evolution of a group of practitioners who call themselves the Radical Midwives.

7.9. Requirements for Social Survival

An analysis of the data gathered in this study led me to suspect that there are at least two steps involved for students in acquiring a midwifery identity. The two-step process may be a function of the fact that midwifery students had, unlike most medical students, already been socialised to an occupation, nursing. Prior socialisation to nursing appeared to initiate some resistance to midwifery socialisation on the part of the students probably because they had already achieved a higher status in their previous occupation. This could be observed in an initial reluctance to identify with midwifery, through constant referral to their previous status, and an eagerness to provide care for women based on a nursing perpective.

One of the problems for students identifying with the midwifery profession is one discussed by Hurley-Wilson (1988) in the context of nursing. In a discussion of socialisation to role she points out that for the average person, role transition is usually from a lower position to one that is higher. Hurley-Wilson also suggests that such a transition is usually accompanied by continuity of role expectations and behaviour. In nursing, such a transition would involve promotion from staff nurse to ward sister where the expectations are continued but expanded and enlarged upon. Some of the behaviours, such as care of the patients, would be the same, while others, such as administrtative duties would be added.

For the midwifery student, social losses are involved, somewhat similar to those that accompany retirement. She is losing her position, autonomy and sense of control over her professional behaviour. The expectations with which she functioned as a nurse are changed and many of the behaviours she has used successfully in the past are no longer required for midwifery. It is not surprising under these circumstances that many students retain and maintain their nursing behaviours in an attempt to obtain some control and stability in their lives.

Observations of the few students who had achieved a higher status in their previous occupation, i.e the status of a ward sister, would support this statement. Although small in number, they were the students, Jodie and Ginny, who complained the most about the midwifery socialisation and took the longest to obtain some type of orientation to midwifery. Complaints included the lack of substance in the classroom theory, lack of identifiable parameters of the midwife's role and a constant reiteration of the

responsiblities they held in their previous job. An additional finding was that these students were the ones who provided the most obstruction to my observations of their behaviour in the clinical area and one was eventually dropped from the study.

The suggestion that an individual's previously held position, if high enough, may obstruct resocialisation when it is required by that individual for a position with a lower status, is an interesting point to emerge from the data. However, one has always to be wary of data from such a small sample size. Nevertheless, it is a point worth pursuing. It is possible that the values sought by the nursing profession when identifying nurses for promotion may be the very values which negatively affect future resocialisation if the new position carries a reduced status. Such values may include, an adherence to hospital policies and well developed administrative qualities. It is logical to assume that, having obtained a position which requires the practice of decision making and control, that any reduction in those requirements through a change in status would lead to cognitive dissonance. Cognitive dissonance will have to be relieved by some form of adaptive measures which I refer to as social survival techniques.

Social survival techniques take time to devise, if they are to function successfully. These are the types of measures that Turner (1956) cites as being demonstrated by individuals who are non-reflexive in role-taking, who do not reflect on their performance and its impact on others within the social environment. I prefer to call them survival strategies or techniques. Although personality may be a factor in the amount of time required to develop and test coping or adaptive strategies, there will obviously be a minimum time required for all students to undergo this process with a successful outcome. A successful outcome could be professional identification. It would appear from my observations that the period required for successful strategies to develop can be as long as six months for the majority of students and may be more, for others.

The fact that some students had initially obtained a higher status in their occupation could lead one to the assumption that more time would be required to overcome the professional and cognitive dissonance in order to become resocialised to a new occupation. However, another interesting fact to emerge was that after initially complaining a great deal to any midwife who appeared sympathetic, the complaints suddenly went underground. In other words, instead of the previous complaints to midwifery staff the complaints were now aired only to the students in their own set. It would appear that one of the coping strategies of these two students was a recognition of the need not to be seen to be

complaining publicly. Thus it would appear that their early adaptive behaviours were aimed more at conforming to current midwifery socialisation than to the acquisition of values and identification with the profession. It could be argued that those who are promoted within a bureaucracy such as the health service are those most likely to conform to the values identified by the service and thus would use conforming behaviours as a survival technique.

However, what is misleading to education and service alike is the fact that these individuals, while appearing to midwifery staff to be identifying with the profession are in fact, adapting themselves to the status quo. This may not involve a covert change in behaviour, other than a reduction in the voiced complaints, but probably represents a learned social survival strategy. Here is a comment about one of these students.

> Teacher "Jodie is such a nice girl and really seems interested.She is always so willing to help and learn. She's way ahead of others in her set". (in relation to midwifery) (Week 15, Set D,trained 9 weeks)

The fact that the staff were misled by the behaviours of these students into believing they were 'midwifery material' could be identified in the many such positive statements made about them versus some negative ones expressed about their counterparts who had I had observed to have identified more positively with the profession. It was the latter who expressed a desire to stay in midwifery once they had completed the course while the former had decided on careers outside of midwifery.

One of the senior managers answering a question on how students acquired the midwife's role seemed to believe that a higher status achieved in nursing correlated with increased adaptability. This may be true but perhaps not in the sense that she identified.

> "I would think it's the ones who've been staff nurses or more senior before they come into the student role who get a fairly quick idea and we do ask that that they should have had some experiences as staff nurses. Again it's a very individual thing how much you actually absorb. I think it depends on how much they are taken up with being students and how much as people they are able to step aside from their role and observe what the role of the midwife is". (Week 10)

It would appear that despite the lack of recognition by midwifery staff of the problems students encountered because of their previous socialisation to nursing, such socialisation created a psychological block which had to be overcome by the students before a midwifery orientation could be acquired. It is possible that if midwifery socialisation in the early stages of training had been more interactive, it could have created a great deal of resistance in the students toward the profession. Anything more interactive or reactive may have been too threatening at a time when the students were feeling vulnerable and could have driven them back to their previous nursing careers.

The main difference between the two socialisation approaches of service and education hinged on the aspect of control and its effect on the behaviour of the student. With the education approach the control was given to the student. In the clinical area this control was firmly retained by most of the midwives. One of the difficulties for the students may have been not so much in the fact that they did not have control, but that the control they appeared to have in their early weeks spent in education had been taken from them by the service staff (Davies, 1988).

As mentioned earlier the junior student entered the clinical area with a perception that she had some control over her learning and this notion was often not disabused by the educators. As the student became more socially aware in the clinical area, she often perceived such control to be in the hands of the strongest individual who may be a member of the midwifery staff. However, overall control of the clinical environment and indirectly, of learning, was in the hands of the medical profession. One of the junior students had already identified this as a problem, during an interview,

> Violet "I think some people are more radical and I guess more interested in fulfilling their role, the role of the midwife ensuring that the midwife carries out the care as opposed to allowing the doctors to intervene. Some people are more passive and they will readily go to the doctors or the midwife in charge". (Week 8, Set C, trained 4 months)

It is difficult to know how much this understanding will affect the student's performance and the type of behaviour she displays in her role. When subjects were asked whether the medical staff affected their learning, the majority of students felt that they did not. Most felt that because they had so little to do with the medical staff they were unaffected by them. Only one student identified that medical control of the clinical environment had an

effect on her learning opportunities. She recognized that such control reduced her opportunities to learn basic midwifery skills, such as caring for a woman who had not been subject to medical interventions or electronic monitoring.

How much of the midwife's behaviour under these conditions is internalised and reproduced by the student when she is a midwife is an interesting conjecture. If it is internalised and reproduced it could provide the answer to what is happening today in midwifery in terms of the slow demise of midwifery as an independent profession. Midwives accepting medical control will not be able to teach or model independent functioning to students. If students do not have the opportunity to learn independent behaviours they will be unable to demonstrate them in their practice.

Midwives appeared to feel powerless in situations where demarcation of role responsibility for a woman's welfare in the maternity unit was not clear. An area where this appeared to be the greatest problem was the labour ward where there was a 24 hour medical coverage. The medical staff, often bored by inactivity, tended to visit the labouring women fairly frequently to assess their progress. Many of the midwives who were very junior by experience appeared unable to exert their authority with the medical staff over the care of women who were deemed to have no problems with their labour. This of course, may have been a function of their socialisation by role models who did not have a strong identity within the profession of midwifery or who as their mentors had modeled powerlessness during interactions with the medical profession.

For students, feeling powerless was a common phenomenon especially during their early training. It appeared that some midwives felt powerless in the presence of doctors despite the fact that they have legally supported responsiblities which cannot be usurped by medical staff. One wonders whether behaviour exhibited to the student during her clinical placement had been obtained from the midwife's own role model during her training. There is also a possibility that the midwives' sense of powerlessness was related to being female while the majority of the medical staff are male. Although not specifically part of my observations, I did note that midwives appeared more able to challenge the female physicians with regard to power negotiations than their male equivalents.

Powerlessness was also a current problem for students when they were placed in a situation for which they were unprepared. One of many such occurrences was for students to be left alone on the labour ward.

> Florence "It was awful the first day. Sister sent me in to look after a lady.Said she would come back and tell me what to do but---the worst thing was the lady was a midwife herself from Argentina and she was really angry with the hospital because she hadn't got a drip". (Week 9, Set D, trained 4 weeks, labour ward)

One senior midwifery manager had a unique way of looking at problems of student's transition to a midwifery orientation. However, her idea appeared to have a less than realistic view of the practicalities of ward and student life when she said,

> "My concern is that they make the student situation so ideal that it actually disadvantages the trained staff because they are run off their feet and the students will look at the trained staff and think, 'well I'm enjoying being a student but I don't know that I could ever cope with the work or want to". (Week 10)

The same manager also stated that observation was one of the important factors in socialisation to a role if the student could first get past the 'glamour' of being a student. This particular manager had not spent time in the clinical area for a considerable number of years.

Disparity between senior and junior managers in terms of the realities of clinical practice was evident in other areas. Junior managers and midwives often complained about the lack of response from senior management to requests for more staff on the wards. This was the reason cited most often by students and midwives as the cause for the lack of teaching of students. The same cause was identified as a reason for expecting students to fulfill a service role rather than be treated as students. One junior sister summed up the situation in the following statement,

> Sister "I don't think the students get enough teaching and demonstration, especially when its really busy. I think they're just sort of left to get on with things far too much. And I think they should be here not as pairs of hands but they should be here as extras and be observing rather than actually used to look after women in labour". (Week 15, labour ward)

Conclusion

In conclusion, an eclectic approach has been used in this chapter, with terminology borrowed from role theory as relevant to the discussion. Some of the problems identified with the application of role theory have been discussed along with approaches to professional socialisation and transition. Socialisation, which is required to bring a person's self perception and behaviour into line with a new role, involves changes, sometimes major in social identity, values and behaviour. This process in midwifery occurs over a prolonged period of time and is associated with role ambiguity when the transition from one role to another is viewed as occuring with a loss of status .

Clausen (1968:133) points out that a role perspective provides a mechanism for viewing socialisation as a continuous and cumulative process. The term 'internalised role' can be used to refer to that part of the self which represents a given individual's tendencies to perform a role in a given way. This is considered different from role itself which is a cultural construct modified by the individual's personality and behaviour. Internalised role has a particular person's mark or style printed on it for it is affected by all the positions he or she occupies and by the interactive ways in which he or she learnt the role.

It would appear from the data presented, that student midwives do not find transition to the student role an easy process. One of the confounding factors is that they have already been socialised to a previous occupation. The fact that the previous occupation was quite similar, yet different, in its behavioural requirements seems also to cause problems of role ambiguity. Many students attempted to recreate their nursing role in the midwifery area and this appeared to interfere with reflexive role-taking in midwifery. Achievement of promotion in the previous occupation of nursing created greater problems of adjustment in such students when transition to the lower status was in the process of evolving.

Previous studies in socialisation to occupations such as the police force and the military suggest that the bureaucracy of the organisations responsible for access to the occupation requires that its employees impose their structure on new recruits. This structure takes the form of 'homogenisation' where recruits are made to appear and behave in much the same manner as each other. Some aspects of this process has also been identified by Davis (1983) with student nurses and was found to be present in midwifery.

One of the major contrasts between midwifery and police socialisation was that the most stressful part for police recruits was their time spent in the academy while for midwifery students it was the time spent in the clinical area. Teachers in the police academy provided boring lectures and required total obedience from the recruits. Teachers in the midwifery school provided an 'idealised' version of midwifery and supported the students as beginning professionals. On the street, police recruits were supported and monitored by a consistent role model while the midwifery students found little support and no consistent role model. As a result each group experienced stress at different stages of the socialisation process but it did occur. While attrition from nursing practice is attributed to inadequate socialisation it is possible that attrition from midwifery is the result of student disillusionment with the 'homogenisation' of midwifery (Lynn, McCain & Boss, 1989). One could not describe this as inadequate socialisation but it may conflict with role the student had determined for herself.

Difficulties with role identification were also compounded by major differences between the Education Department's definition of a midwife's role and that of the service staff. Such difficulties left the students in a state of dissonance until they become experienced enough to accept one or both definitions. These problems may be reduced or exacerbated by the type of midwifery role models to whom the students were exposed.

Interpersonal competence is a vital attribute of persons participating in being successful members of a society. Social competence is the outcome of role relationships through which individuals are equipped with the appropriate role skills and strategies to enable them to shape the responses of others in order to successfully achieve their own goals and role related goals. The fact that some of the midwifery role models had not achieved social competence in their profession could be a complicating factor in a student's identification with midwifery. In early socialisation, midwifery students display stereotypical responses as outlined in this text. When the individual's behaviour increases in range and in the complexity of responses within the role, stereotypical behaviours decrease. When this occurs there is some evidence that identification with the profession has occurred (Hardy and Conway, 1988).

The vast majority of students appeared to accept the Education Department's definition of midwifery while practising the definition provided by the service staff. This was in evidence in the student's expressed approval of midwives who practised the expanded role in line with the educational definition versus disapproval expressed for those perceived to

practise within a contracted role. It is possible that these students were reacting to their socialisation in a way decreed by the organisation, that of passivity. Social pressure undoubtedly played a part in students complying in the clinical area with a definition of midwifery of which they disapproved. This ambiguity between practice and service could be one of the causes of role anxiety and conflict discussed in the next chapter.

CHAPTER EIGHT

ROLE ANXIETY, EXPECTATIONS AND CONFLICT

This chapter will discuss students' anxiety in the clinical area and the relationship of this anxiety to their expectations of themselves and the environment in which they learned their skills. Many students experienced anxiety as a result of conflict between their expectations and the reality of the clinical learning environment. A major problem which created conflict was that students' expectations were largely formulated from information provided by their educators. Midwives in the clinical environment tended to function from a service perspective which rarely included provision for the students' learning role. Conflict between expectations and clinical reality led to an increase in anxiety which created even more conflict in the students. Increased and prolonged conflict tended to lead to decreased self esteem and a sense of powerlessness.

Lack of clarity concerning role expectations was also a factor in producing anxiety. It created ambiguity in clinical practice with which students were often unable to cope. Such ambiguity was exacerbated by midwives who did not evaluate the students' previous learning experiences in order to plan their present learning requirements. Working with different midwives on each shift helped to maintain ambiguity as many of the midwives functioned from different perspectives of midwifery practice.

Students who did not yet have a clear identification with midwifery, such as those who had just entered training, also revealed a low self esteem which was not so evident in the majority of the students who had been in the programme for some time. While such low self esteem could be related to an individual's lack of knowledge of midwifery and the skills required for social interactions, there were other factors involved. Some of these factors will be explored in the context of the student data presented.

8.1 Anxiety

Lazarus (1966, 1976) in his seminal work on stress and coping suggested that anxiety can be either a cause or a response to stress and that coping is a form of problem solving to deal with difficult situations that are perceived by the individual to be stressful. The application of these ideas would appear relevant for this study because is clear from my

earlier descriptions of the prevailing conditions on the teaching units that students perceived themselves to be exposed to stress and devised various methods to cope with it. But whether such stress is a cause of anxiety or a response to anxiety needs to be examined in light of how it will affect the students and the types of coping skills they devise.

The usefulness of Lazarus' work to this study lies in its broad interpretation of stress and the treatment of anxiety as both a response and a stimulus for action. His own definitions have a certain logic when applied to this data despite their lack of specificity. One useful aspect is the notion one's motivation to overcome threat may be an important factor in how one copes with new experiences. An interesting addition is his discussion of the work of Ausbel, Schiff and Goldman (1955) on the effects of self esteem on anxiety, the importance of which will be discussed in detail later in this chapter.

Lazarus uses the term psychological stress analysis to distinguish his definition from other types of stress analysis. The difference is clearly identified by the intervening variable of 'threat'. 'Threat' is used to imply a state in which one anticipates a confrontation with a harmful situation. One evaluates cues by a cognitive process of appraisal which assesses the power of the potential harm and whether one has the resources to counteract it. In addition one's underlying values, beliefs and motivation are factors in how one will respond to the situation, i.e. is it worth it to stay and fight or should one extract oneself from a threatening situation through flight.

According to Lazarus anxiety is an inevitable accompaniment of being threatened. If the threat stimulus is located and regarded as overpowering, then fear as an affective state will replace anxiety. If the threat stimulus is seen as vulnerable to attack then anger and aggression will ensue. Anger alone may be the result in situations where agression has had to be inhibited because of the fear of an increasingly punitive response. If the threat cannot be located or if the threat is ambiguous there is no focus for attack or any other action. Therefore no alternate emotion or action can replace the anxiety. Intuitive appraisal of a situation initiates an action tendency that is felt as emotion expressed in various body changes and may lead to overt action. The type of action chosen is determined by the individual's motivation, resources and the potential and nearness of the threat. Observable emotional reactions to threat will depend upon the nature of the coping process activated.

There are several difficulties in applying the hypotheses of Lazarus to a clinical setting. The first is of a contradictory nature. The broad definition of stress so useful for a general

application to this data serves to inhibit the specificity with which one normally can apply a definition. In addition the practical application of his concepts is left to the individual researcher because Lazarus discusses them only at a theoretical and often abstract level of analysis. While he describes the psychological processes resulting from the exposure of an individual to a threatening stimulus he does not provide an exact definition of stress or sufficient rationale to enable the reader to determine the advantages of his pyschological definitions over those of other researchers. His rationale is that the term 'stress' has been used in such an eclectic fashion in research studies that to define it would be to lose several important aspects of the stress and coping process. As a result he uses it as a collective term to encompass the study of the psychological processes, such as appraisal of threat and coping, brought into play when individuals are exposed to their perceptions of stress. While there is no strict definition of terms he does discuss a variety of studies supporting different definitions.

One could argue that to use a term to cover an area of study and not define the concepts used is illogical. How can a concept be studied when its constructs change with the differing perceptions of the researcher? However, Lazarus supports Kaplan's (1964 :70-71) argument that to provide premature closure on meanings of a concept could have a damaging effect on scientific progress. Lazarus (1966) resolves the dilemma for himself by stating that such discrepancies occur as a result of varying levels of analysis by researchers from different disciplines, such as physiology, sociology and psychology. His suggestion is that each brings a different approach to the study of stress which broadens our understanding of it.

An additional problem is that Lazarus simplifies his explanation to the point where he gives the impression the human individual functions in isolation when psychological processes are brought into play. While there is an implicit assumption that threat may be appraised in different ways as a result of interactions with others, the role of the 'other' in affecting the appraisal of the threat and perceived coping skills is treated in a superficial fashion. Lazarus appears more interested in the play between pyschological and physiological processes than in the factors of the situation which produce an individual's responses.

Despite these problems Lazarus is useful in helping to identify the perspective other authors use when discussing anxiety. Quinn (1989:402) describes anxiety as a response to stress, an unpleasant emotion which occurs in anticipation of threat or harm and results in an increase in arousal. Pagana (1988) utilised the same definition of anxiety as Quinn for her study of baccalaureate nursing students in their first clinical experience in a hospital in the United

States. Using a combination of qualitative and a quantitative methods, Pagana identified students' greatest anxiety as being related to a fear of failure. She also found that fear was related more to not knowing what to do in the clinical area and thus making a grave error than to failure in the course although the latter was an aspect of perceived stress. Collection of data was through a clinical stress questionnaire with a Likert scale. She did not identify how many questions it contained or it's validity and reliability. The front page of the tool contained open-ended questions which asked the student to describe their clinical experiences from the perspective of stresses, challenges and threats. Of the 262 nursing students in the sample 77% expressed feelings of inadequacy related to having to meet what they felt were unreal expectations. They perceived themselves to be given responsiblity for patient care far too early for their knowledge level. Stress was created by the expectation of staff nurses and their instructor that they would be able to make decisions about patient care for which they had insufficient knowledge.

The findings of Pagana's study supports those of a British study by Parkes (1985). She interviewed 150 first year nursing students from two schools of nursing 6 to 7 weeks after they had commenced their first clinical experience. Three major categories emerged from the content analysis; issues concerned with care of the dying patient, interpersonal conflict and a fear of failure with procedures. Interpersonal conflict was a theme identified by Kleehammer et al (1990) who were interested in studying the levels of anxiety in students which they felt had not been adequately addresssed in the literature. A convenience sample of 39 juniors and 53 senior nursing students was obtained from a baccalaureat nursing programme in the U.S. Data were collected over a period of four years by means of a clinical experience questionnaire which was developed by the authors. The tool was developed from the literature, interviews with students and the author's own experiences. There were 16 items which included communication and procedural aspects of patient care, interpersoanl relationships with nurses and with educators. In addition to the 16 items was one open-ended question for students to identify what had been the aspect of the clinical experience which had created the most anxiety. The tool achieved a Cronbach alpha reliablity coeffiecient of $r = 0.82$ and factor analysis was performed for construct validity.

The results of Kleehammer et al's study were somewhat similar to those of the researchers above. They found a high level of anxiety in 88% of students which was related to their fear of making errors and 83% of students were anxious about their initial clinical experience. The levels of anxiety were quantified; there were significantly higher scores on anxiety between seniors and juniors on 6 items on the scale. These were; talking with patients (p

=.001), talking with a patient's family (p = .03), Procedures (p = .01),hospital equipment (p =.03), patient's a.m care (p = .01), initial clinical expereince on a unit (p = .05).

The interesting aspect of all of the studies described above is that they had very similar outcomes regardless of the data collection instruments used. In addition, one study was British and two were from the United States. The former assessed students in non baccalaureate training programmes and the latter two in baccalaureate programmes in different parts of the United States. Baccalaureate programmes in the U.S cannot be compared with non-degree programmes in Britain for several reasons. In Britain, the approach to nursing education is through apprenticeship and the students are considered to be a part of the ward staff. They are supervised in general by the ward staff and may or may not see an instructor on a daily basis. In the U.S students are not part of the hospital staff; they are closely supervised on a daily basis by an instructor who assigns them their patients. Despite these differences in the clinical context, which one could assume would have altered student anxiety levels, the same foci of anxiety are expressed. Anxiety as a response to stress which has been perceived by students was created by the uncertainty of their knowledge, other's expectations and their fear of failure as a result.

Nursing students in another U.S. study identified anxiety as a response to their perceived vulnerability to the disparaging comments of their instructor and staff nurses on the wards (Windsor, 1987). Such vulnerablity is due to a lack of status common to all students regardless of their career choices. Lack of status in midwifery students, discussed in the previous section, had a negative effect on the students' self concept and may result in a fear of failure.

Any reduction in self esteem is likely to pose a threat and thus create anxiety because the student would be likely to feel that she would be unable to cope with any clinical situation. However, it is probable that any type of anxiety created as a result of transition in role is part of a developmental process required for adaptation to a new situation. In this sense, anxiety may be the key motivating stimulus on the student to devise and develop the strategies necessary to survive in their new role. Davies (1988) noted many methods students used to reduce their anxiety when it was related to a low self esteem. One method was 'doing the obs' and another was to 'bite their tongue' and attempt to 'fit in' with the social work pattern of the unit. For Dingwall's (1977) group of student health visitors it was 'storytelling', an attempt by the students to reduce the importance of those who posed a

threat to the students' self esteem. These methods will be described in more detail later in the chapter.

It is also likely that anxiety as a motivating force, whether it is a response to or a stimulus for stress, can only be tolerated for a limited period of time. Beyond this unspecified period it may become a debilitating force creating fear in the student to the extent that she is unable to function well in her role. As Quinn (1989) states, every individual has an optimal level of arousal at which they perform at their best. Under- or over-arousal results in deterioration in the performance of learning tasks, particularly those of a complex nature.

> Roberta "I'm anxious if I don't feel in control of the situation I'm in. Or if I'm left in a situation and I don't feel capable of dealing with it. I imagine what will I do if this happens? I just don't feel in control". (Week 56, Set E, trained 9 months, interview).

As discussed earlier, anxiety may continue unabated if a threat to one's psychological well-being is perceived but not located or if the threat is ambiguous. This may be the case for junior students who, as a result of their lack of status and knowledge in the clinical area feel exposed to a potential threat because they are unable to bring an expertise to the clinical area. In the case of unrelieved and prolonged anxiety which has no direct focus, it may be that the only option open to a student midwife would be to withdraw from her new profession. This has been noted to be one of the options which student nurses exercise when under extreme pressure and stress (Quinn, 1989). The fact that this rarely happens with student midwives prior to completion of the course may indicate that they have either learned the appropriate strategies with which to survive successfully or they have the motivation to cope with the threat. Another possiblity is that the anxiety is relieved by periods spent with positive midwifery role models. They may reduce the student's stress through the provision of sufficient knowledge and encouragement to enable the student to survive brief periods of anxiety. They may also provide the knowledge and the modeling for the development of coping skills in the student. The Education Department which provides one study day a week for students may also facilitate their adaptation by supporting their concerns at the times when they experience anxiety-provoking situations. I believe a combination of factors provide the most reasonable explanation.

Lack of status, discussed in the previous section, had a negative effect on the student's self concept. A drop in status frequently created feelings of vulnerability which were likely to have a negative effect on the individual's confidence and self esteem. Any reduction in self esteem is likely to pose a threat and thus create anxiety in the student because the student would feel that regardless of what she was exposed to she would be unable to cope. In this context anxiety is the stimulus for the creation of stress. It is probable however, that any type of anxiety created as a result of transition in role was part of a developmental process required for adaptation to a new situation. Anxiety may be the key motivating influence on the student to devise and develop the strategies necessary to survive in their new role. Davies (1988) noted many methods students used to reduce their anxiety when it was related to a low self esteem. One such method was 'doing the obs' and another was to 'bite their tongue' and attempt to 'fit in' with the social work pattern of the unit. For Dingwall (1977) studying student health visitors, the main method used was to reduce the importance of those who posed a threat to student's self esteem through storytelling. These methods will be described in detail later in the chapter.

A combination of lack of knowledge and poor supervision would appear to be two anxiety-producing factors present in the following statement made by Fiona just after I had arrived on the special care baby unit.

> "Its a shame you didn't catch us in the beginning fumbling around. I was scared to death. They were really busy, very busy. ....You feel really frightened and alone and not capable of doing anything. But once they showed you what to do, it wasn't bad and now, I really enjoy it." (Week 29, Set C, trained 9 months)

Ambiguity plus a lack of supervision appeared to create a stressful situation as identified in the following statement by Lynne,

> "Postnatal ward was fine because I worked my first week there with a midwife and she supervised me and I got confident. But on the other wards I was working with different people and getting different ideas and I wasn't at all sure at the beginning especially on labour ward or even here in S.C.B.U". (Week 55, Set E, trained 38 weeks, special care baby unit, interview)

Not knowing what to do in a clinical situation leads to a feeling of vulnerability and anxiety arising from fear of doing something wrong. Again, in this sense, a non-focused anxiety was the stimulus for stress because of the fear of not coping. Another factor, not stated above but implicit in some of the students' statements, was not only the value of knowing what to do and how to do it but also a need to be identified as part of the midwifery team. Feeling the need to be part of a team has been identified in the nursing literature with regard to students in training as nurses (Jacka & Lewin, 1987; Ogier, 1989).

As noted earlier, anxiety can be created when the individual does not have the skills required for an occupation or profession (Davies, 1988; Ausbel, Schiff & Goldman, 1953). The latter group of authors believe anxiety is a reaction sensitivity suffered by individuals who have an impaired self esteem. This impairment leads the individual to overreact with fear to any situation which may have the potential to further threaten their self esteem. In other words, stress is created in the individual by poor self esteem and this initiates fear and a nebulous anxiety because of the potential for more psychological distress.

Given this definition it is logical to assume that anxiety would be a common problem in the early days of training when there is a greater uncertainty about what may happen which could constitute a psychological threat to the self esteem. In the later stages it could be expected that the student would have more knowledge of what was expected and developed coping skills accordingly. Many of the more junior students became anxious when placed in clinical areas where they believed the superficiality of their knowledge would be exposed. Anxiety detracted from their image of themselves and left them feeling reduced in status. Such feelings are described in the following statement.

> Florence "I felt awful facing that woman when I knew so little. I wonder if they ever feel cheated or feel they are getting second class service having a new student like me looking after them?" (Week 12, Set D, Trained 9 weeks, antenatal clinic)

Florence's comment was typical of similar concerns expressed by other students mainly on behalf of their clients and supports the results of Kleehammer et al (1990), Pagana (1988) and Parks (1985). The feeling expressed was that these clients were not receiving appropriate care due to the lack of knowledge of the student. Many students felt guilty about this when caring for pregnant women and this is turn created further anxiety as well as feelings of guilt.

Anxiety regarding poor client care was more often expressed by junior students than senior ones and this finding is supported by Kleehammer et al (1990) with nursing students. It is probable that senior students have more knowledge, are more aware of and can cope with what happens to women in the clinical environment and may feel they can offer more to the client in the way of care. It is also possible that the senior students' familiarity with the requirements of the clinical area and the staff facilitated a reduction in anxiety because they felt more able to seek assistance when necessary. Another factor for junior students may have been that they were closer to their nursing background where the type of care they were used to providing would have been reasonably expert. Such care was very different from that which they were presently providing because of their lack of knowledge in the midwifery area.

Anxiety in the clinical area took many different forms and many factors were responsible. Much of the students' anxiety appeared to stem from the uncertainty of the clinical area especially in terms of the staff's expectations of them. A statement by one of the midwives emphasised that many practitioners perceived this to be a problem for the junior students.

> "I think they're thrown in at the deep end with no idea what's expected of them or how much they have to do, how much they have to know and what they need to ask."

As was commonly noted in such interviews, the expectation of the clinical staff was for the student to control her learning environment and identify her own learning opportunities. The reality was somewhat different. Even when the student was provided with the opportunity to state her learning requirements they were rarely heeded or addressed to the level which the student felt was required.

In all fairness to the clinical staff, it should be noted that these were difficult times for the provision of care in the health care system. A shortage of personnel and resources and a new grading system for midwives left the staff feeling demoralised. The fact that over a hundred midwives felt impelled to appeal against their grading level left staff with a poor impression of the value the hospital placed on their role. A combination of staff shortages and low morale left many of the staff with little empathy or desire to try to understand students' learning needs or anxieties.

Students perceived the midwives to be unaware that even the more senior of them were prone to attacks of anxiety when placed in unfamiliar surroundings.

> Bronwen "I was anxious in special care because I was unsure of my practice, unsure what was expected of me. I think the whole situation was very stressful and on labour ward too. Especially when they're busy and on night duty when you're left on your own and the bell's ringing and there's nobody to answer it and you see the baby's heart dropping and there's just nothing. Well, you do what you can do and you're just waiting for someone and its just awful then." (Week 18, Set B, interview)

Bronwen had at this stage completed twelve months of her training and was giving a retrospective account of her time spent in the special care baby unit and the labour ward. The labour ward experience continued to bother her despite the fact that it had taken place six months earlier. The recalling of negative episodes experienced as a student was a common finding with other senior students and recently graduated midwives. Bronwen, in common with many of the students took every opportunity available to discuss the 'horrors' of the labour ward and frequently brought these experiences into conversations with me especially during the periods in which I was observing her.

Many of the senior students on the labour ward made statements which indicated their perceived lack of status and poor self concept. For example, when anyone on the labour ward, such as a doctor, shared information or skills with Bronwen she was always quick to tell me that they did not do so normally and only did so now because of my presence. It is possible that this was true but does not negate the fact that she perceived others as thinking she was unworthy of being taught unless someone with a higher status, such as myself, was present.

The junior students' lack of status was reflected in their low position in the hierarchy of the labour ward. This low status had been perceived by the students as having a negative effect on staff teaching. My observations revealed that this perception was probably correct. The lack of teaching was due to the fact that students were not seen as a priority except in terms of outcome skills to be completed. These skills were identified by the ENB as requirements for students in order that they may qualify as midwives. It is possible that

without such formally stated skill requirements the students would have received even less instruction in them than what they actually obtained.

On first entering an area, such as the labour ward, students were immediately made aware of their lack of status. After the reading of the report, the students rarely received recognition from the senior midwife until the last midwife had been assigned to a client. This can be easily understood in the context of an imminent delivery of a woman in labour, but it also happened when no such urgency was required. Some of the senior midwives would question the students about their previous experiences but rarely with any depth or detail. Basic questioning was concerned with the numbers of skills they had performed and how many they still required rather than the students' feelings of confidence in performing such skills. If students expressed doubt about being able to perform in an adequate fashion they were often brushed off with a 'you won't learn until you do it' attitude.

> Susan "I was told off by sister for not doing a booking. I told the midwife this morning that I don't feel confident. I did a booking and missed out lots of things. I feel the poor women suffer because I forget things. Anyway, here I am, doing one". (Week 10, Set D, trained 6 weeks, antenatal clinic).

The lower esteem in which some students were held on the labour ward could be seen in the type of tasks they were given. They were often delegated by some midwifery sisters to relieve midwives for coffee breaks, wash newly delivered women and transfer women to the postnatal wards. However, when they were almost due to leave the labour ward there was an interest expressed by the senior midwives with regard to how many deliveries they had obtained, how many vaginal examinations they had completed and what additional skills they required. Students who were short of experience in any of the outcome skills provided on the labour ward were then given priority over other students and midwives in order that might obtain them. Most midwives recognized that students were taught only when the service demands allowed such teaching. As one sister told me when I was with a student, "She's just a pair of hands today, no teaching today".

It was not uncommon for students to be asked questions which cast doubt on their ability to perform some skills, such as taking a blood pressure. Taking a blood pressure was a

skill in which most student nurses had achieved competency long before the completion of their training.

> June "There were probably one or two occasions where they sort of double checked a blood pressure or something, which used to aggravate me. Being asked silly things like 'can you do blood pressures?'. I've probably got more experience than them. I can think of one or two particular people who I have more experience than". (Week 14, Set A, just qualified, interview)

To have such a skill questioned by the midwifery staff was perceived by students as very degrading and emphasised to them their low status in the midwifery profession. An added insult was that any conflict between the midwifery staff and students and the medical staff, with regard to the recording of blood pressures was deemed to be due to the inexperience or poor technique of the midwifery staff, rather than any error on the part of the medical staff. Many students and midwives accepted this despite the fact that the majority of them had taken many more blood pressures than the medical staff and thus could be assumed to be more proficient at this task. When such conflicts occured, both midwives and students were left in no doubt as to their lower status in relation to the medical staff.

It is not fair to state that this was the situation for all students. It did depend on the person in charge of the ward at the time and which midwives provided supervision. Some sisters and midwives were much more motivated towards teaching and assessing students while others clearly saw them primarily as service staff. However, even those who were motivated often received little encouragement in their efforts from the senior midwives.

Although nursing research has identified the ward sister as the most important figure for student nurse learning, this was not the case on this site (Jacka and Lewin, 1987). A reason for this may be that junior sisters in midwifery were usually very involved in the clinical care of the client and rarely in the administration of the unit. The labour ward, because of the expertise required in emergencies, was staffed with several sisters, one always in a senior grade. As a result, the junior sisters behaved in a somewhat similar fashion to the rest of the midwives and were just as involved with teaching, while the senior sister was very involved in the administration and rarely seen by students.

For some of the junior students, the lack of teaching was less of a problem than was coping with the transition process from staff nurse to student. It was only when adaptation

to this change was fairly complete that the students were able to pay attention to their learning needs. The junior students appeared not to notice the lack of teaching they received and how much service they were expected to provide. It was the more senior students who complained about being treated as service staff rather those in their junior period.

The problems the students experienced with their status would appear to be one of the developmental phases through which they must pass in order to progress through the programme. It would seem that midwifery staff play a large role in this process, a fact which some students treated with hostility. One student, complained of her treatment by staff, stating that they had "stripped her of her nursing expertise". She went on to explain that she felt this way because of the midwives' disregard of her previous training and their treatment of her as if she had no knowledge with which to provide care to maternity clients. Whether the behaviour exhibited by the midwives assisted or inhibited the students' progress towards receptivity of learning is difficult to assess in terms of the data available. However, it is a factor which has some significance for student transition and should be further investigated in order for it to be accurately identified in policies for student learning.

It was only when the student had more familiarity with her environment that she was able to progress from her transition difficulties and become more receptive to learning. Problems which exacerbated the transition difficulties was the junior students' lack of midwifery knowledge plus exposure to a large number of new experiences and these led to a situation where they were unable to cope with additional information from the environment. This point has also been identified in a previous study of student nurses (Pagana, 1988). Some students recognised this and felt reluctant to move when they felt they were finally acquiring some skills and knowledge.

> Susan "I'm leaving the labour ward. I don't want to leave because I'm just getting into it---and now, moving elsewhere". (Week 25, Set D, trained 20 weeks)

The large number of new experiences plus the lack of a cognitive framework on which to hang the information led to many students suffering from information-overload.

The senior students experienced anxiety from other causes. For them, anxiety arose out of a concern that their knowledge base was not sufficient for the level they had reached, particularly with regard to the skills and knowledge required for the labour ward. Although anxiety was expressed when students worked in other areas of the hospital, such expressions were far more frequent when related to the labour ward and the special baby care unit. In both places there was the potential to damage an infant if incorrect care was given and this was the major focus for such anxiety. Another reason for increased anxiety was that students were often expected to take on more responsibility in these areas with little attention paid to whether they felt either confident or competent.

> Maureen "I had a bad trace the other night. I called sister. She popped in and popped out just as quick to inform someone else. Then I got more dips so I rang the bell. I thought 'sod it I've done everything I can'. Night sister came in and stayed until it picked up but then I was left on my own and the baby got tachycardia. So I stood outside and yelled to sister what was happening and she said nothing" (Week 17, Set C, trained 6 months, labour ward).

Anxiety was not just related to fear of not knowing but also to the fear of what might happen because one did not know. This anxiety occurred even though students recognised that, as students, they could not be held responsible for any adverse outcome which might arise as a result of something they did, or did not do. Their previous roles as nurses left them with residual feelings of reponsibility which they were unable to ignore. This type of anxiety was less realistic for junior students who tended to be monitored more closely and given far less responsibility than the senior students. Nevertheless, the latter's anxiety appeared just as great, especially when they felt they had insufficient skills for coping with a situation when left alone with a client.

> Jackie "Quite often I've been anxious mainly because when they're busy you do tend to be left on your own. That's usually the main problem. You just don't feel you're getting enough supervision and you feel that stressed sometimes. Being with patients that you're not sure of--you need a little bit more supervision at certain times than others". (Week 25, Set E, trained 5 weeks, postnatal ward).

Anxiety due to poor supervision often led to sleepless nights for students at all stages of training and this in turn created more anxiety for the next shift. While midwives perceived

themselves to be providing close supervision of students the students felt they were frequently left alone. For the student, supervision meant the midwife spent most of her time with her and the labouring woman. For the midwife, supervision meant that she was available in another room if needed and would come if she was called. The reality was that often, when the student did call, the midwife was unable to come because she was needed by a second woman for whom she was providing care. Students appeared more likely to recognise this reality than the midwife, possibly because the latter was not experiencing anxiety. It is probable that the midwives provided the amount of supervision they felt was needed by the student which was insufficient for what the students felt they required. Students rarely complained to the midwife about the lack of supervision and midwives rarely assessed the students' need for closer supervision. In other words, no one talked.

A few of the students expressed reservations about midwives who had not trained at the study site. They appeared to feel that the practices of these midwives were suspect and, therefore, such midwives could not be counted upon to provide adequate support in a stressful situation. It is probable the students had gained this perception from other midwifery staff.

> Violet "Everyone was so busy and I had been left with this new midwife who knew nothing and the monitor showed type 2 dips and the registrar wanted to know why I hadn't been concerned. I told her I was and had told someone an hour before but they had been too busy to come." (Week 9, Set C, trained 5 months, labour ward)

It is interesting to note here that the registrar approached Violet and held her responsible for the situation rather than the more senior person present, the new midwife. This treatment of new staff who had not trained on the study site would appear, at this time, to be generally accepted by all staff throughout the labour ward. However, another possibility is that the registrar, unfamiliar with the new midwife, was wary of criticizing a new member of staff when she was not sure of the type of response she might receive. The student was in a much more vulnerable position and was not expected to challenge her.

The fact that the new midwife herself was probably also feeling the need for support would have occurred to Violet under normal circumstances, but not in the present situation. In her own personal need for support, she did not appear to want to identify with the midwife's problems other than to the extent of the effect on her practice At this

time, Violet appeared quite stressed which was revealed in the fact that she was not as verbose as usual and seemed unable to discuss the more difficult aspects of a recent delivery she had performed, which she had told me she had found frightening. She used a standard communication blocking technique which will be described in more detail in the next chapter. This technique has been described by Kirkham (1989) as one frequently used by midwives to avoid answering women's questions. This technique was very much in evidence in this labour ward and was probably the place where Violet had first observed its use.

> M.C "First one alone?"
> Violet "Fourth"
> M.C. "First one without someone scrubbed?"
> Violet " Yes----Must find out about that tear"
> (Week 4, Set C, trained 4 months, labour ward).

Although many midwives were aware of the problem of poor support for students, few seemed able or interested in taking any action. Even fewer appeared clear on what the issue was although some were able to identify a few of the components. One such person was a junior sister on the labour ward who, when asked if she thought students were anxious, laughed and said,

> "Oh yes, I think so. But again. I mean, I suppose if they met you for the first time I think they are. Because I think they always think they are expected to know this, that and the other and obviously it's best to admit that you don't and then we can teach you".

Although she identified some of the problems, it appeared from this statement that this sister believed the solution lay with the student. This may have been due to her style of administration. She believed in administration through autocracy and the delegation of all tasks to others. It is also possible that having trained in midwifery under similar circumstances to those of the students, the sister failed to understand why they could not get through if she had.

In the main it would appear that midwifery staff had no clear idea of what caused anxiety in students, each having only her own training experiences to fall back on to help identify any problems the students experienced. Very few of the staff who identified anxiety as a problem for the junior students were aware that the same problem could exist in the senior

students. Many students felt the junior midwives were more sympathetic to their problems than those midwives who had been practising for some years. This, of course, would support the view that midwives related present student training to their own training experiences, the older midwives being the furthest removed from their student days and the least aware of current student 'problems'.

8.2 Loss of Face

With the senior students it was possible to hypothesise that some of the anxiety experienced was related to what I would call 'loss of face' (Ausbel, Schiff & Goldman, 1955). In this situation, loss of face or a sudden loss in self-esteem was the result of an interaction in which the student was perceived by another individual with higher or equal status as exhibiting less than the required amount of knowledge for a specific area. Such a situation is often related to socialisation aspects of nursing where being in control of a situation is 'role modeled' to a student when the nurse role model is interacting with the medical staff or patients. Appearing less knowledgeable than you would wish indicates that you do not have the degree of control over the situation that you would hope to convey to someone with a higher or equal status. A student's lack of control in such situations is usually perceived by trained midwifery staff to be the result of a poor knowledge base.

Loss of face was not a phenomenon observed in the very junior students. This was largely due to the implicit acknowledgement by everyone, including themselves, that their midwifery knowledge base was poor, despite their nursing education. However, it was a fairly common phenomenon with the senior students. Loss of face was especially prevalent in senior students if they perceived their knowledge to have less depth than their colleagues in the same set. These were unreasonable expectations given that the differences in knowledge could arise as a result of exposure to different learning opportunities in the clinical area.

However, students were often unaware of the depth of knowledge of others in their cohort. Some students made the assumption that their colleagues had more information than they actually possessed, presuming them to be functioning at a higher level than they were themselves. If a student demonstrated or revealed to others that she knew less than what she believed was expected for a specific situation, she tended to assume she was 'less intelligent' than her colleagues. This in turn led to a loss of confidence in her own ability

and a subsequent loss of self esteem, whose extent tended to be influenced by how much the she believed her lack of knowledge was related to either a lack of intelligence or to a lack of learning opportunities, or a combination of both. The more experienced students were able to make this distinction more readily than those in their junior period. The severity of the loss of self esteem was related to whether the student experienced a minor drop in confidence (loss of face) or a prolonged loss due to non-supportive and negative assessments from the midwife who was her mentor. It is logical to assume therefore that a loss of self esteem would create anxiety in a student because of the potential threat that she would be unable to cope when faced with a challenging clinical situation.

Strength of motivation for professional entry can also be a factor in determining study practices and other techniques of obtaining information. As Howe (1981) points out, a high level of motivation is a necessary condition for human achievement and, conversely, negative motivational influences, such as fear of failure, lack of confidence and a feeling that one's fate is largely controlled by external factors rather than by oneself, almost certainly have effects that restrict a person's learned achievements. Identification with the profession was a major motivating force discerned among students in this study. While there was evidence of negative factors, such as those mentioned by Howe, these factors did not appear to have an overall or prolonged effect on learning, although they created anger and frustration in students. Such emotions seemed, ultimately, to provide the students with the incentive to seek out different midwives from those who had created the negative feelings as sources for their learning opportunities.

> Mabel "I find they can be petty about little things like the cot card. I was told I had to write Konakion on, so I did the next time and I was told off. It makes me reluctant to initiate things". (Week 14, Set D, trained 5 weeks, labour ward)

Student anxiety generally began to be reduced at about the six month level of training. This would appear to be related to two factors.

1) the student was becoming successful at taking on both the student and the midwife's role as defined by the organisation.This adaptation made the students more acceptable to the staff but still created some conflict in students who felt they had compromised on the 'true' role of the midwife;

2) the student had begun to develop a theoretical framework with which to guide her performance and behaviour. In other words, after about six months of training and socialisation to midwifery, aspects of the more reactive approach to socialisation, as identified by Becker et al (1961) began to appear, aspects such as the questioning of their role in practice. This is not to say that such questioning did not happen in the earlier days of training but rather that at that time it was mainly confined to a comparison of the worth of their previous occupation, nursing, and their new profession. Not all students achieved the stage of questioning their role with the midwife, although the majority did it within their cohort and with the educators whom they felt were more sympathetic to such questioning.

It would appear that the students required approximately six months of theory and clinical practice before they were able to relinquish their old identity and take on and adapt to the role of a student. This was the period of time students needed to discard redundant nursing practices and absorb the midwifery culture in order to identify with the role of the midwife. My observations of the students revealed a consistent pattern of change in behaviour over the first six month period. Windsor (1987) referred to this behavioural process in nursing students as the stages of professional development. The students began their programme by carrying out nursing tasks, such as taking the clients' temperatures. Where possible they avoided talking to the women in order not to expose their ignorance. In some instances they even appeared to blame the women for making them look ignorant.

> Susan "I hate it when they (the women) ask me questions like — how long will he have mucus? Put me on the spot like that". (Week 9, Set D, trained 4 weeks, postnatal ward)

As they became more familiar with their identity as students and midwives, they became more willing to talk and identify themselves, as students, with the women. Once they became comfortable with the student role they began to react more positively to the expectations midwives held for them. Reaction in many not only took the form of questioning but also took the form of negotiation with midwives in an attempt to form what they perceived to be more appropriate roles for themselves. In addition, some of the more confident students attempted to expand their role beyond the parameters provided by the midwife to meet the definition given to them by the educators. One

example was Janet who complained to me after a delivery and went on to complain to the midwife who supervised her.

> Janet "I don't like being pushed into hastening a delivery like that--its against my better judgement. She wasn't ready and she only got tired pushing it out when she wasn't quite ready". (Week 7, Set B, trained 10 months, labour ward).

8.3 Midwifery Transition Tasks or Stimulus Overload?

As suggested earlier, the junior students would enter the clinical area with an apparent inability to take on board more than a limited amount of information from their experiences. Some would stand and talk to women in labour, apparently ignoring indications that suggested that the woman or the fetus could be in distress. It would appear from observation that the students were unable to respond to more than a limited number of stimuli. One could argue that being novices they were not able to recognise or identify certain problems of a complex nature. However, without exception, these students had been told the warning signs for maternal and fetal distress and when it was appropriate to call the midwife. The lack of recognition demonstrated by the junior students for these problems would suggest that they suffered from a stimulus overload to such an extent that they were unable to respond in an appropriate way to new information, however vital.

It could be hypothesized that increased anxiety levels in students would enhance the effect of stimulus overload. Lazarus (1966) believed that high degrees of threat to an individual's psychological well-being disrupted cognitive functioning and could encourage primitive and inadequate solutions to cope with it. Observations of Sarah, one very junior student in the labour ward, would support such an hypothesis. In this example, Sarah was working alongside her mentor when it became necessary for the woman they were caring for to have a cesarean section. Although some of the skills required for this surgery are much the same as for nursing, Sarah did not appear to be able to transfer them to her new context. She stood in one corner of the room not appearing to notice that the scrub midwife and the doctor needed their gowns tied up. Later, when the anaethetist requested drugs, I had to respond because Sarah did not appear to hear the request. The scrub midwife dropped bloody sponges at Sarah's feet and she appeared not to notice until asked specifically by the midwife to count them. At that time she proceeded to pick up the sponges with her fingers even though there was a set of forceps for the purpose. She then laid the sponges

on the floor in front of the rack on which they should have been hung. Her actions suggested that a stimulus overload compounded by anxiety led to 'thought blocking' behaviour.

Similar passive behaviour was exhibited by other junior students to a lesser degree. I noted junior students who appeared not to notice changes in fetal heart patterns, audible in the room, and even with fairly senior students who ignored warning alarms when they were first placed in the special care baby unit. One could certainly argue that anxiety could and probably did interfere with students processing information especially in situations where the skills were already present from nursing. Another factor may be that in some of these situations the problem was noted by the student but not responded to because of a fear of 'doing the wrong thing'.

A similar situation to the stimulus overload hypothesis was observed in the antenatal clinic when Maureen with 6 months training was unable to respond to a woman's needs during a booking visit.

> Maureen "First baby?"
> Woman "No, second. I lost one at six months, died inside me."
> Maureen "What is the date of your last x-ray?" (Week 16, Set C, antenatal clinic)

This student had previously demonstrated many caring attributes so that the non-caring attitude evident above was not the reason for her inappropriate response. I believe she was applying a rote learning technique in order to remember what was required of her when booking a woman for pregnancy. This adherence left her no room for listening to the content of the communication with the client other than on the superficial level required by the form. Another possibility is that the student was distancing herself by turning off the conversation because she felt unable to deal with the emotion engendered (Davies, 1988).

Benner (1984 :21) in her study of novice nurses describes the above behaviour as 'rule-governed'. She suggests that since novices have no experience of the situation they face they must be given rules to guide their performance. She goes onto suggest that the same situation would occur with any trained nurse when placed in an unfamiliar situation. While this suggestion may be part of the explanation for what is happening with student

midwives, it does not provide an explanation for why, when provided with a set of rules, the students failed to respond appropriately. Therefore, the stimulus overload hypothesis would appear to retain some validity.

Without the knowledge to deal with new clinical situations it is difficult for the student to know what is the 'right thing to do'. I believe that part of the problem also lies in the fact that the roles of nursing and midwifery are similar enough in some performance areas so that students have to reject or disassociate from the former in order to take on the latter. It is also possible that the midwives' rejection of the students' nursing background as providing them with skills for midwifery, facilitates the students' rejection of their previous occupation, while creating dissonance in them until they have managed to identify themselves as a midwives. Rejecting or disassociating from nursing may be the only way some students can achieve such identification. For those who fail to reject their previous profession, anxiety would probably increase inversely with a decrease in self esteem.

8.4 Clinical Areas Which Created Anxiety

Some areas were seen as threatening because of the amount of anxiety and stress associated with the role of the midwife in that area. Such an area was the labour ward. The amount of anxiety and stress felt by the junior midwives as well as some of the more senior staff working in such areas often translated into a less than caring attitude toward the students. It was as if the stress and anxiety associated with the area left the practitioners bereft of a sympathetic response for them.

> Florence "They didn't explain about the A.R.M (artificial rupture of membranes). Sr X said they wouldn't rupture her membranes because of her previous section then Sr Y ruptured her membranes. She put in a uterine catheter but never connected it. I asked if I should put on the external (monitor) but sister said, no we'll connect the internal (monitor) but didn't. Sister X came in and said we'd better start recording". (Week 10, Set D, trained 6 weeks, labour ward).

Most of the midwives were caring individuals, as was amply demonstrated through their responses to women. However, many of them appeared to have no emotional energy left to expend on caring for the needs of the student. This was most evident when the unit was

extremely busy and understaffed rather than when it was quiet with a high staff-patient ratio. It was possible to differentiate between midwives who were confident in their practice and those who were less so, as the former were the most likely to provide the students with an empathetic response when it was required. Although the students accepted the cause of their treatment, it did not make it any easier for them to tolerate it and it often created even more anxiety. There were other areas perceived as threatening, but not for the same reasons. The threat here was not due to the stressful working conditions but because of the personality and expectations of the staff.

8.5 Student / Staff Conflict in Expectations of Midwifery

One area which created a great deal of anger in students because of the personality and expectations of the staff was the antenatal clinic. Most of the complaints were concerned with their perception that the clinic midwives lacked interest in teaching and held negative attitudes towards education. There were also complaints that the midwives functioned within a restricted role, and were perceived to be passing on their responsibility for decisions to the medical staff. Complaints were also voiced that the midwives acted as obstetric nurses with many not palpating or completely assessing the clients for whom they were caring. This situation had also been noted by Robinson (1985) in her study of the midwife's role. Florence complained about the restricted role of the midwife in the antenatal clinic which she did not perceive to be providing either a service for the women or a good role model for students.

> Florence "Well, the first day was awful---that was the general consensus of the group. It was them or us--I must say I felt really rushed--like everything's on a conveyer belt. I feel the midwives are handmaidens--don't take responsibility. I expect them to do more--nearly all the patients are seen by the doctors". (Week 6, Set D, trained 2 weeks, antenatal clinic).

The complaints emanating from the antenatal clinic were not all from the students. The midwives in the clinics complained about the students, stating that they had unrealistic expectations of them, given their working conditions and the shortage of staff which was prevalent at that time. They also blamed the shortage of staff and the large numbers of students in the clinic for restrictions in their midwifery practice. They felt that, given the staff they had, they were unable to function in a more independent fashion, such as running midwives' clinics instead of running the clinic for the doctors Much of the midwife's role

seemed concerned with keeping the clinic running smoothly for the doctors and any attempt by them or the students to act like midwives interfered with this efficiency. What was interesting was that neither the students nor the midwives blamed the medical staff for the restrictions in the midwife's role, despite the fact that they had some responsibility for the problem.

> Midwife "Sarah, if you keep an eye on here for one of the doctors you can go in with her. She's (registrar) in such a hurry today and we have to keep the clinic moving". (Week 6, Set D, trained two weeks, antenatal clinic)

It was quite clear from my observations that inexperienced students were frequently left alone in a room to assess women. Many felt a great deal of anxiety because their lack of knowledge was exposed to the women when they attempted to respond to their questions. It was also clear that the clinic midwives were more interested in 'keeping the medical staff happy' than in teaching the students.

Midwifery teachers generally seemed to recognise when questioned that the students' lack of skills induced anxiety, but they appeared to accept this as a normal function of being a student.

> Teacher "I think anyone going into a new area is going to feel anxious and it's to do with being unfamiliar about what's required of them and the fear that they may actually be given too great a responsibility for what they know."

The fact that the fear of responsibility was a fairly realistic fear at times, especially in areas such as labour ward, was not perceived to be enough of a problem by the educators for them to take any action, such as frequently entering the clinical area. For some of the teachers who had been in education for some time, there was a fear that they would reveal themselves as deficient in clinical skills if they entered the clinical area in support of their students. In my view, this was the main reason for their lack of clinical support for the students and was often recognised as such by the midwifery staff.

Many students who found themselves too inexperienced to cope with certain situations used extremely graphic words to describe how they felt.

> Janet "I found it very, very stressful (labour ward) For instance I was almost conducting a delivery on my own, waiting for someone to answer the bell and I was there with the patient, delivering the baby, just waiting for help and I didn't think that was very good at all". (Week 53, Set B, trained 16 months, interview)

Other students, discussing their experiences on the labour ward, talked of being 'confined' in a room, 'isolated' and 'imprisoned'. The strongest and most graphic terminology expressed by students at all stages of training was that used to refer to the time they spent in the labour ward.

Many of these students found the labour ward so stressful that they would take any opportunity presented to verbalise their feelings about the experience. This occurred even when the students had been finished in the labour ward for several months. It may be that the high tension of such a unit, the type of tension which surrounds areas where death is an ever-present possibility, provoked such anxiety in the ill-prepared students that they were unable to initiate early coping strategies. Lack of coping strategies would create a stressful cycle which would produce even more anxiety. The presence of a supportive midwife tended to go a long way toward breaking such a cycle.

> Marion "I've got a mentor who's good and even if you're in a room there's always someone to help you. Easier than being confined on labour ward. Easier to get to know people down here. You feel confined if you're in a room on your own and you know they (midwives) are busy". (Week 22, Set C, trained 8. 5 months, postnatal ward).

Although anxiety was rarely expressed by senior students, when it was, it was related more to personality and conflict with the midwife than to the lack of knowledge, skills or status noted in the junior students. One student who experienced such problems felt frustrated by what she felt was a lack of options in her dealings with the midwife.

> Ida "One particular time when I was working with a midwife and it could be due to a personality clash but I wasn't happy with her work and her practice. As a student I found it difficult to protest and to an extent I felt I had to do my work but I wasn't happy working with someone whose ideas I didn't agree with. I found it very difficult to contradict someone who's younger but more senior than me". (Week 57, Set B, qualified 4 months, interview)

This anxiety appeared to be due to the lack of available options for the student when she disagreed with her mentor about her practice. The conflict may have been initiated or compounded by a clash of personalities. It was certainly compounded by the frustration felt by the student when she was dealing with someone who was senior to her in midwifery practice but younger than her in age. Such a situation as this meant that although the midwife was senior to the student in midwifery experience, the student would have been more senior if they had both remained in the nursing profession. At times such as this students often felt compelled to revert to a comparison of their own nursing history with that of their mentor in an effort to demonstrate that, even though they were students, they had the experience to make clinical judgements. This could create its own dissonance because one of the reasons this student was unable to challenge her midwife could be attributed to socialisation practices in nursing which required junior nurses not to challenge those in authority.

This kind of conflict was not uncommon with the senior students and generally revolved around the teaching they had been given by the Education Department which, as mentioned, was often at odds with clinical practice. It also appeared to be an effort to demonstrate an expertise which they felt they had but which they were not given the freedom to demonstrate. In other areas, such conflict would be perceived as a 'rite of passage', a demonstration of one's ability to have mastered the complexities of the profession. This type of behaviour was only in evidence when the students were working with the less popular midwives.

While many midwives appeared to recognise the problem of anxiety few appeared to have any strategies to assist the students. One midwife did not believe it to be a problem because,

> "there are enough staff, and they (students) have mentors and they're followed around."(Postnatal ward)

Although the above statement was sound in theory, many mentors were placed on rotations opposite to those of their students, and consequently, spent little time with them. In such cases the student might be on a day shift while the mentor was placed on night duty. In one situation, the student spent a total of two days out of twenty five with her mentor who went on holiday for three weeks on the second day of the student's rotation, and then onto night duty. The student was placed with many different midwives and had difficulty persuading one to evaluate her practice. Evaluation of the students was something that many of the midwives were reluctant to do especially if they were not the mentor. This was because many had spent so little time with the student that they felt it would not be a fair assessment and the student was considered not to be their responsiblity.

It became increasingly clear that having midwives act as mentors to the students was a strategy 'imposed' by the educators on the service staff with the result that the midwifery managers did not feel compelled to support the measure. Indeed, it appeared to me that some managers took pains to sabotage the strategy by deliberately placing students with midwives who were going on holiday or night duty. Many of the midwives recognised this as did the educators, but it took the students to say that the mentor system was not working. This problem was clearly stated by the students when I sat in on their evaluations at the end of their programme. These evaluations, to which the clinical managers were invited, were fairly formal occasions conducted by the teacher responsible for that group of students. The complaints made by the students were nearly always a repetition of those made by previous students. Unfortunately, it was rare for changes to take place, partly because the educators blamed the managers and the managers blamed the educators.

8.6 Social Competence

The earliest weeks the students spend in the clinical area have been identified by Davies (1988) as the most difficult because it is the period when students are attempting to place some structure in their lives. Davies suggests that it is a problematic time because the students have lost relative strength and status which had earlier been gained from time spent in the school where they enjoyed the safety of numbers. Leaving the relative safety of the school was threatening to their self-image and sense of identity.

This same loss of relative strength and status is somewhat similar to that described by Dingwall (1977) with health visitors and relates to their transition from the nursing profession. In Dingwall's study of student health visitors, conflict was thought to be a result of the transition to student status. He felt that the student health visitor suffered partly as a result of the loss of power and control held by them in their previous nursing position. However, he determined that this was more of a problem for health visitor trainees than for midwives or nurses because they were socially more competent. He considered that the fact that the trainee health visitors were usually older meant that they were more socially competent than younger nurses who had more recently graduated.

It is not clear why he included midwives in this assumption, as many are of a similar age to those entering the profession of health visiting and have as much to lose with their professional identity. I would also argue that social competence is not necessarily a factor in an anxiety-provoking situation. It may be a factor with regard to the external presentation of coping, in other words, the physical appearance of a calm demeanor, but not in terms of internalised anxiety. After all, one cannot say the young child on his first day at school is less anxious because he is lacking in social competence. I believe anxiety and social competence are two threads which may run together from time to time but are not necessarily cause and effect in outcome.

Few of the senior students expressed anxiety but, when questioned, admitted the condition on occasions. Therefore, I would support Benner's (1984) suggestion that fear of the unknown can create levels of anxiety in all people. However, social competence in previous situations can increase internalised anxiety when the individual is faced with an totally new situation, which is thought to require the capability of externally presenting a confident appearance. I believe the latter part of this statement is in line with Dingwall's hypothesis. However, whether conflict creates anxiety or anxiety creates conflict is somewhat like a chicken and egg syndrome and probably quite circular in its process.

8.7 Lack of Institutional Support for the Midwife's Role

There was also an implicit recognition that the focus of the institution was on the safety of and service to the clientele. This emphasis often left students with feelings of frustration due to the number of guidelines formulated for the care of women, particularly with reference to the use of technology. The guidelines overemphasized the use of technology in the care and assessment of women leaving students with few opportunities to assess

women using non-technological midwifery skills. Students felt that the use of technology prevented them from learning basic midwifery skills and decision-making. This was due to the fact that many midwives treated the guidelines as standard policies and rarely demonstrated other means and skills for assessment and monitoring. All of these guidelines were formulated by the institution for the inexperienced and insecure midwife in order to protect their clients and not necessarily as a policy for all midwives to use.

> Myrtle "Maybe we are lazy as midwives--developing skills which rely on monitoring (electronic) too much. Don't use the pinnard as much as I should. I'm scared to death of moving from here where there isn't any technology". (Week 4, Set B, trained 9 months, labour ward)

The recognition that the institution was only interested in producing midwives who could work within its environment was identified fairly early by the students, particularly with regard to the priority placed on service needs over those for the education of students. This recognition created a different anxiety in the senior students who were closer to the completion of their training and were concerned about their skills for working outside the study site environment. Bronwen was concerned about the role socialisation she had been exposed to because of its possible limitations on her future career

> "I appreciate that this is a high-tech, busy unit and understaffed but we feel we are not prepared for anything except to work here. No one ever discussed the difference between high and low risk women because everyone here is monitored---unless they refuse. They put clips on so that students who're only here for 6 weeks can be left with the patient. I mean anyone can recognise a dip and tell sister."(Week 26, Set B, trained 15 months, labour ward)

8.8 Service Role Expectations

The service role was defined by the midwifery staff as the need to get work done, i.e women cared for, doctor's rounds attended and the appropriate documentation completed. Some midwives were more in tune with the institution's needs with regard to the service role than were others. Students on some wards and in the clinic were expected to get their work completed before any expectation of teaching could be met. For the student, practising skills with a midwife by her side was regarded as a reward for work done and not as a necessary part of the her role. Factors such as this negatively affected the

student's search for a role identity. In Kramer's (1974) study, nurses who behaved in a similar manner to that evident in some midwives, were identified as bureaucratic. Kramer felt that such characteristics were responsible for students experiencing conflict and dissonance when they compared such behaviours with the theoretical education they had received.

There was a recognition by both midwives and students that the role of the midwife was ambiguous at the best of times. That the role meant different things to different people created anxiety in most students. This was verbalised by Ida,

> "You gets lots of ideas because of the different approaches of the midwives.You build up quite a repertoire — I'm not sure if that's good." (Week 27, Set B, trained 15 months, antenatal ward)

A complicating factor for the student's clinical education was that many midwives appeared to genuinely believe that the student had to 'do the work' in order to learn the role. However, their definition of 'doing the work' encompassed many things, from serving meals to fetching linen in addition to personal contact with the clients. The wards always seemed short of equipment or linen and so a lot of time was spent by students searching the hospital for replacements. Many midwives subcribed to the belief of 'trial and error' as a learning tool although it was rarely stated in those words. The knowledge that the students required some supervision and demonstration prior to practising their skills seemed to be lost in meeting the needs of the clients.

Another problem identified was that some students had unrealistic expectations of the area in which they worked. They perceived the area in a positive way if they obtained many learning opportunities but in a more negative light if these opportunities were minimal. This theme was highlighted in the view expressed below on the postnatal ward.

> Susan "I find I'm not learning enough—I don't feel I've learnt as much (here) as on the labour ward. Maybe it's that there's not much to postnatal care. Here, you have to go and find them and ask. Have to keep asking them."(Week 19, Set D, trained 14 weeks, postnatal ward)

I suspect that one of the problems here was that the postnatal wards did not create as much excitement as the labour ward nor did it provide for a completion of tasks. In the

labour ward a student can follow a woman through her labour, assist in the delivery, check the woman and the baby and then discharge them to the ward. On the ward, the tasks as presently performed are fairly routine and do not provide completion, as the woman may be in for several days. This type of experience is not perceived by the student to be exciting and does not provide the same sense of achievement and satisfaction as that which accompanies the birth of a baby.

Another factor may be that the woman in the labour ward is more dependent on the midwife for her care than when she is on the postnatal ward. Indeed, the ethos here was to assist the mother in increasing her independence from the midwives in the care of herself and her child. This was done in order to prepare the woman for discharge when she would be caring for her child with little professional assistance. For those students with a strong nursing identity, this lack of dependence on the part of the client may create dissatisfaction.

8.9 Process of Midwifery Identification

As the students began to feel comfortable with their role, their behaviour began to be characterised by a more reactive response in keeping with Thornton and Nadi's (1975) stage of informal expectations. Here, the student passed from the formal stage, where conformity to the organisation's requirements is greatest, to the informal stage, where she begins to focus on the qualities of the individual midwife rather than on the expectations related to the position. Thornton and Nadi believe the individual cannot reach the informal stage without satisfactorily mastering the expectations required for the formal stage. These are often mastered through compliance with the expectations of the system.

> Ginny "I find you have to tread carefully. Don't do anything and don't say anything. Some people I don't bother to ask because I don't trust what they tell me". (Week 10, Set B, trained 10 months, labour ward)

Evidence of the first two stages was supported by my observations when the students began to react to experiences by identifying midwives who they deemed to be 'good' role models and those they perceived to be 'bad'. The type of criteria for such role models appeared to have come from the Education Department. This type of identification was not in evidence with students in the early months of their programme but appeared at approximately the six month stage of their training and depended largely, at that time, on

how stressful they found their clinical environment. If the student was enjoying a positive experience, the midwife was perceived in a positive light. This was probably due to the fact that to provide a positive experience, the midwife had to possess the qualities the student deemed appropriate. What the student was often measuring was the midwife's ability to pass on her knowledge and skills. The two qualities are not necessarily the same, although often treated as such by students and midwives.

Even when students demonstrated some reaction to their experiences, it was not until much later in the socialisation period that they revealed any kind of occupational commitment and even that appeared to fluctuate with their feeling of well-being in whichever clinical area they were based. Janet, who had been in training for 9 months, still remembered with some anger, her earliest experiences and the effect of that clinical area on her group.

> Janet "Four of our group started in the clinics.We were down there for six weeks and hated it and were ready to quit midwifery. Before I went down there I talked to a student ahead of us. She's a midwife now. She told me it's what you get out of it, if you're enthusiastic and don't let the pressure get to you, you'll be O.K". (Week 8, Set B, labour ward)

Additional power losses experienced by the student were related to the changes in the clinical environment. The student would spend some weeks in a clinical area where she would learn organisational tasks and midwifery skills. She would also become familiar to the midwifery staff working there who tended to become more accepting as the student demonstrated an increasing independence from their support for her skills. Students who identified closely with the institution's policies and the likes and dislikes of the midwifery staff were even more acceptable to many staff than those who did not conform so well. Having achieved some sense of belonging in that area, the student was then transferred to a totally new environment where many of her previously learned skills were not useful. She was also expected to learn an entirely new organisational system and interact with a new group of midwives. All of this created a fresh anxiety until a sense of belonging could again be achieved. Even the midwives found the student changes to be difficult and disruptive.

> Sister "Sometimes the allocations are too short. In some areas when they only have 2 weeks it's difficult for the ward staff to get to know them properly and it's difficult for the student to feel relaxed". (Week 11, informal interview, postnatal ward)

8.10 The 'Intelligence Game'

An important requirement for eliminating anxiety in junior students was a consistent role model. A consistent role model meant having the same midwife spend the majority of the student's rotation in the clinical area with her, in order to facilitate her understanding of what was expected. This was viewed as a necessity by students in their junior period, because they did not have a clear idea of how they should function and what the expectations were for their performance. Unfortunately, this was not recognised by many midwives. As a result, the student was often placed with many midwives while working a rotation (usually 4 weeks) and would obtain a very confused idea of what was expected. This confusion was increased by the fact that some midwives trained in places other than the study site, and had different ideas concerning how a midwife should practise.

> Ida "It's alright in the senior period when you've developed a technique but I don't have the confidence right now because 13 of my 15 deliveries were with different midwives. It did occur to me once or twice to ask for the same midwife but then I thought someone might get offended. I wouldn't have the confidence to ask". (Week 6, Set B, trained 9 months)

This lack of recognition was particularly problematic for the senior students as the expectations were greater for them than for the juniors. Those who had been supervised by many midwives in their junior period were still not clear about their role and often demonstrated a lack of confidence in their performance. An additional problem was that having previously spent time in a clinical area they were expected to remember what to do when they returned. This supposition obtained irrespective of the number of places in which the student had spent clinical time and the time that had elapsed since the student had last worked on that particular unit. No one appeared to feel a need to reorient the students to the unit environment but expected them to just pick up where they had left off, usually about six months earlier. Some impatience was expressed with students who had difficulty doing this, so that many attempted to hide the problem.

Unfortunately, the demonstration of 'good' clinical skills appeared to be equated in student and midwives' minds with 'intelligence'. Therefore, to be perceived to be functioning less well in an area than another member of the same set, was equated with being 'less intelligent' than the other. This in turn led to a reduced self concept. Students went to great lengths to disguise a lack of expertise if they encountered midwives who obviously thought this way. Sarah was a junior student who was back on the labour ward for the second time.

> Sister "Why don't you go and check the resuscitaire. You know what to do, yeah?"
> Sarah "Er-- yes, I think so"
> Sister "You've done it before?"
> Sarah "Yes" (Week 23, Set D, trained 5 months)

Sarah left and went into the labour ward where she found another midwife checking items in the cupboards.

> Sarah "Sister asked me to check the resuscitaire---I'm not sure if I can remember how?"
> Midwife "Its over there" (pointing).

This is not to say that students were the only ones to have this problem. Midwives were also very reluctant to admit to students and to one another that they lacked knowledge in a certain area. Implicit in Sarah's statement was a cry for help which was ignored by the midwife. I suspect that the reason it was ignored was because the midwife herself did not feel confident enough about resuscitaires to teach the student how they should be checked. It is also possible that the midwife was distracted and not really paying attention to the covert message relayed by the student. It is important to note that Sarah did not feel able to follow up on this conversation with a direct request to the midwife for help. This particular behaviour does not appear to be confined only to the health professions, Schon (1983) identified a similar type of behaviour in architectural students.

This approach in attitude and behaviour was quite prevalent with students with regard to the theoretical component as well as the clinical area. It could be observed with particular clarity in the run up to exams. At this time it appeared to be unacceptable to say that one had studied for an exam, the implication being that, if you were intelligent you had no need to open a book. It is not clear where this mythology came from but I suspect it was

brought by students from their nursing training. Some students denied studying even when it was clear that they had done so by their demonstration of an adequate or superior amount of knowledge to that of their peers. It was obvious to most people that such a level of knowledge could not have been achieved except through studying Despite this, many of the brighter students played the game. A comment by one junior student about a fellow set member illustrates this point.

> Susan "Mabel makes me so mad. She always says she has never opened her book but I know she studies until quite late at night. Why can't she admit it? She always comes top so what's her problem?" (Week 28, Set D, trained 23 weeks, interview)

This incident serves to emphasise the point that some students, as well as some midwives, equate intelligence with doing well in the course while not being seen to study. I suspect this is a move on the part of the students concerned to improve their self concept. Unfortunately, it created hostility in other students who did not fare so well in the exam stakes. This hostility may in itself serve a purpose, in that it improves the self concepts of the students against whom the hostility is directed, those who 'play the game'.

8.11 Student Conflict

One of the main causes of anxiety in the students was conflict in the work situation. The causes of such conflict were multiple, whether due to the supervising midwife's personality, unclear expectations for students' performances or the emphasis on service rather than clinical teaching. Directly or indirectly the conflict was concerned with the student's role versus that of other members of the staff, such as the doctor and the midwife. Any situation which had the potential to create anxiety had the potential to cause conflict. Whether the conflict can be ascribed to the student's attempts at identification with the midwife fulfilling the role, or with the performance of the role itself, is another question.

To illustrate what is meant I will rework some of the processes just discussed using different anecdotal material. One student emphasised the tension that she felt had existed between students and midwives in the early days of her training, in one particular clinical area. She believed that such tension was a result of a conflict in role expectations.

> Sarah "Well, the first day was awful (on antenatal clinic.). That was the general consensus of the group. It was them or us — I must say I felt really rushed — like everything's on a conveyor belt. I know the midwife has to get the ladies in and out but I feel there's no talking to the patients — and the palpations. I feel the midwives are handmaidens — don't take responsibility. I expected them to do more". (Week 17, Set D, trained 3 months, postnatal ward)

This type of work-related conflict is an example of what happens when the student has a strong desire to learn and perceives that to be a major component of her role, while the midwife appears to only be interested in 'getting the work done'. It is also an example of a student's preconceived idea of role, possibly as a result of information provided by the Education Department, which she then finds is not matched by the midwife's behaviour in the clinical area. Another student who was behaving in a fatigued manner attempted to get herself moving with the following statement,

> Fiona "Is that the time? I seem to be getting slower. I'll be getting into trouble if this continues". (Week 23, Set C, trained 8 months, antenatal clinic)

What was interesting about this statement was that Fiona seemed to be divorcing herself from her body. It was almost as if, in her anxiety, she was removing the guilt of slowness from herself and placing the blame on a third party over which she had little control, her body. It is also clear that she was expecting to be chastised by the midwives if she did not increase her level of activity.

Other anxiety or conflict-provoking situations were caused by the role models themselves. The reputation of midwives perceived to be hostile or negative in their approach toward students was usually passed from student to student with the result that many of them feared meeting such models. Similar experiences were recorded by Davies' (1988) group of midwifery students. Mandy complained about one sister she had worked with.

> "She could be really abrupt and rude. When I saw I had her my heart dropped---I quaked in my shoes". (Week 4, Set C, trained 3 months, labour ward)

Even when the midwives were not perceived as hostile, but demonstrated inappropriate behaviours, the effect was somewhat the same on the student. Again, the example here

came from the antenatal clinic where Marion had been writing her assessment in the woman's notes.

> Midwife "Why did you write in your findings? The doctors don't like that". (Week 4, Set C. trained 3 months, antenatal clinic)

Other problems experienced in the service area for which little preparation had been provided was the hierachical nature of the ward administration. The Education Department was very non-hierachical in its dealings with students and it is possible that the students suffered some conflict as a result of the differences between the two philosophies. This was particularly true if the students were taught by the educators to challenge practice, as this tended not to be well received by the service staff. Service staff appeared to have an expectation that while the student was there she would 'fit in' with the ward routine and practices. Several students had complained about this system, which was not usually as explicitly stated as in the following anecdote,

> June "On the antenatal ward I worked with a midwife who told me things to do and how not to upset the sister". (Week 12, Set A, trained 16 months, postnatal ward)

This 'sussing out' of what the appropriate behaviour should be in order to cultivate a satisfactory relationship with the ward staff and the ward sister was also noted by Davies (1988) with midwifery students, and Alexander (1982) and Melia (1982) with nursing students. Such behaviours would appear to be standard coping strategies until students feel sufficiently advanced in their training to challenge or negotiate with such authority figures.

Personality conflicts also caused anxiety especially when the students felt frustrated by their lack of power in such a situation. Although the educators had told students that personality clashes could be dealt with by a change of midwife, most students felt unable to negotiate this with their teacher. Although the teachers appeared approachable, the students seemed to feel that, to a certain extent, it was failure on their part when this type of conflict arose. As the teachers rarely entered the clinical area this could have also been a factor in the students not approaching them. One midwife addressed the problem of inconsistent role expectations between service staff and students partly by placing the blame with the students for not conveying to the staff how they felt. She felt that the

students were frequently placed in situations where they gave advice without being sure of their knowledge base,

> "I think they're often anxious that they're doing things and saying they can do them but they're not really certain of what they're doing. When you do interviews with them you find they're not nearly as happy as you thought they were. They're really worried about what they're doing". (week 21, interview, postnatal ward)

However, the same midwife went on to say that she felt that students knew more than they were aware and that they were supervised more than they believed they were. This demonstrates a difference of perception between students and service staff. From my observations I believe the true picture lies somewhere between the perceptions of the two.

A major cause of conflict lay in the fact that many students expected the role of the midwife to be an extension of nursing in which nursing skills could be utilised. While some were aware that midwifery represented the 'healthy' aspect of care, as opposed to the sick role to which they had been exposed, they appeared unprepared for the extent of role change that was required.

> Joanne "At least if you do----say, coronary care, there's a patient there and at least you can do the nursing. But in midwifery the patient asks you about breast feeding or a rash or jaundice and you think---the more they ask the more worried you get. The more you go to them the more they ask, so in the end you try and stay away". (Week 13, Set A, trained 16 months, postnatal ward)

The main difference between the two professions was in the area of 'talking vs doing'. In midwifery the woman would question the student on aspects of pregnancy, labour and delivery. The students found this very difficult because they had been used to 'doing' for patients who were often too sick to question them with regard to care or health problems. In addition, the students had previously been in situations where, if the patient was to question them, they had the appropriate answers. Now, because of the requirements for a different set of skills and knowledge, they felt uncertain and anxious and developed a number of strategies for overcoming the uncertainty. Joanne clearly determined that the best strategy was to go as infrequently as possible to the client.

It could be argued that the fact that students and staff differed in their perceptions of the role of the midwife could provide the potential for role conflict between the two parties. This potential could be exacerbated by the students' perception that their role had an educational perspective not recognised by the clinical staff. Additional fuel for conflict was the tendency for some midwives to use policies frequently to legitimise any reduction in their role. Because midwives rarely provided the students with a rationale for the use of such policies, the students were loath to accept their use and saw it as a further erosion of the midwife's role. They believed the midwives had accepted such erosion voluntarily.

The students were inclined to focus on the functions of the role and whether or not they were allowed to practise their conception of what a midwife was supposed to do. This may be part of the process which Davies (1988) describes of students redefining their functions as they evolved into the student role. For example, Maureen who was five months into her training stopped me in the corridor to describe a recent experience on the labour ward where she was presently working.

> "Should have been here yesterday, I delivered a patient in the left lateral--was really brilliant---a really good delivery, was good to see the perineum". (Week 11,Set C)

Such students were anxious to inform me whenever they felt they had achieved an expansion of the role that I had not observed. It was almost as if they felt they had let me down by not performing according to what they perceived to be my expectations. I believed I had been very careful to be non-committal concerning my expectations of their clinical practice but it is possible that a different message was conveyed. Janet felt it necessary to make comments concerning other midwives' performances as if she considered herself to be an objective and professional observer of such practices.

> "Not many midwives here feel confident about suturing. Would only be a couple at the most". (Week 5, Set B, trained 38 weeks, labour ward)

Other students sought to inform me of the lack of confidence expressed by midwives in their presence or overheard by them. It is possible that the students used such expressions of midwives' inadequacy to bolster their own egos and sense of vulnerability with regard to the practise of skills. What was obvious was that the majority of students focused primarily on skills competency rather than on a cognitive knowledge of their role. This

appeared to be part of the process of 'fitting in'. 'Fitting in' seemed to be inextricably linked with the service component of the role and the requirements of the midwifery service staff (Davis, 1983).

Strategies used to influence role-related goals are associated with the relationships and the social identities of the actors. Clinicians act to establish for themselves acceptable definitions of the situation. Midwifery staff often act as if students are not in a position to judge their needs and requirements for themselves while holding the expectation that they will make their needs known. Furthermore, some midwifery staff, through routinised activities, restricted interactions and communication with the students. Various distancing strategies performed by some midwives did not assist the students in their development of skills and a professional commitment and identity.

8.12 Methods for Reducing Anxiety

Lazarus (1976) identified two types of coping methods which he felt individuals used to deal with stressful situations. The first method he referred to as direct action where the behaviour of the individual is directed at changing their relationship with the environment. Such an action could take the forms of preparation against harm, avoidance or aggression. The second method referred to as palliation, was directed at moderating the distress through symptom-directed and intrapsychic modes. Symptom-directed modes included the use of substances such as alcohol or drugs or muscle relaxation techniques. The intrapsychic mode encompassed defence mechanisms such as denial, repression, projection and intellectualisation.

8.12.1 Threat to Leave

Different methods were chosen by students to reduce anxiety but some demonstrated a desperation at the perceived lack of options available. Fiona, one of the students nine months into her training, reflecting back on her experiences as a junior student in the antenatal clinic said,

> "I wanted to leave on the first day. Some of my set never want to come back here". (Week 15, Set C, labour ward)

In the above description it is clear that it was important to Fiona that she had a choice of using avoidance behaviour if her anxiety and stress became too great. It is also possible that this student was making this threat so that someone, either in the school or the service

side, would take her seriously and listen to her concerns. The threat to leave was the major strategy for coping among the junior students. Such a threat was rarely used by the senior students. The fact that junior students rarely left would reveal such threats as more of a comfort measure than a serious challenge. However, it is possible that those who made the threat to leave during their training were the ones who left the profession once their training had been completed. Unfortunately, this was not an area that was examined or which has been referred to in the literature.

One cannot tell from Lazarus and Folkman's (1991) description whether they have considered the importance of having a choice for reducing anxiety. However, one could assume such an idea is implicit in their description of anticipatory coping where individuals project ahead to what they believe may be a potentially threatening situation. To deal with such a threat they appraise their choices for coping and select one accordingly. The success of such a choice will ultimately rest on the 'reality' of the situation and threat that they have anticipated.

It is logical to assume that junior students would distort their anticipated reality through a lack of knowledge of the characteristics of the context. They may imagine such a 'reality' as offering a threat because they lack the knowledge to deal with a clinical situation. As a result the coping strategies and choices they identify may not be suitable for the purpose. For the older students this type of situation may be perceived as a challenge instead of a threat because they feel able to apply their knowledge and skills.

8.12.2 Doing the 'Obs'

Most of the junior students took refuge in continuing to demonstrate behaviours previously associated with the nursing role. These behaviours which consisted of tasks, such as 'doing the obs', could be carried over in a limited fashion from nursing to midwifery. This type of coping skill could be considered by Lazarus (1976) to be one of direct action, preparing against harm. Continuing to perform previously learned nursing skills may be perceived by the students as an action which prevented them from being asked to perform other tasks for which they had less knowledge. It may also have had other purposes. It could have enabled students to avoid situations where they would otherwise have to reveal their lack of knowledge in front of a client. Davies (1988) felt that it enabled student midwives in her study to feel part of the organisation and could also be viewed as an interim coping measure in the transition from nursing and 'doing' to

midwifery and 'communicating'. Such behaviours also enabled students to demonstrate some competence in an area that was otherwise fairly alien to them. It

Despite this need to demonstrate previously acquired skills, the students appeared to shut out any midwifery expansion of 'doing the obs' until they were more comfortable with the setting and had become suffficiently familiar with the formal expectations of their role. This may be due to an inability to successfully exchange this coping skill with a more appropriate one until they had been able to adjust to the new 'reality' of their experiences.This 'shutting out' was observed in junior students who would take 'the obs' at every opportunity but not think of expanding the practice to include other aspects of the mother's care, such as an observation of the baby's condition.

Davies (1988) suggested, as a result of her study and a perusal of other literature, that routinised nursing tasks, such as 'taking the obs' protected the student from dealing with the emotional strain of continually working through new interactions with the client. 'Taking the obs' does provide distance from the clients in that it prevents them from asking questions which would expose the student's lack of knowledge. It is possible that Davies' suggestion has some basis, given the fact that some of the students in this study appeared not to respond to information given to them, while consistently rushing to 'do the obs' at every opportunity.

It was also hypothesised that these behaviours protected students from having to negotiate with medical staff from a position of weakness (Davies, 1988). Such a situation concerning the medical staff was not evident as a problem in this study. Students were rarely involved with the medical staff who sought out more senior midwives with whom to communicate. If the junior students were approached by the medical staff it tended to be only for them to identify the whereabouts of senior staff. However, it could be said that junior students made little attempt to communicate with medical staff and appeared to avoid any situation which would have created such an opportunity.

What was evident was that the students did obtain some comfort in undertaking familiar tasks because they perceived them to have a shared meaning with midwifery. This could be observed by the quickness with which they responded to suggestions from midwives that they perform such tasks and the faithfulness with which they continued to do them, against all odds, such as the woman requiring assistance in labour. A sense of judgement, which many of these students would have demonstrated in a nursing situation, was

curiously lacking during the students' early exposures to maternity care. I saw more than once a junior student attempt to take the temperature of a woman who was having strong contractions. Women in this condition were quite capable of biting the thermometer into two pieces due to the pain they were experiencing. The pain often left the women unaware that they even had a thermometer in their mouth. Such students would probably not have attempted a similar approach to physical assessment when working as nurses with patients in extreme pain.

8.12.3 Storytelling

It is difficult to place storytelling in the coping framework proposed by Lazarus and his colleagues. The main reason for this is that the coping skills they describe are intrapersonal. As identified earlier in the chapter, Lazarus (1966, 1976) appears not to address the interaction of the individual with others in the environment except where such others have the potential to create a threat or a challenge. If such 'others' can affect the environment by creating a threat to another individual it is only logical to assume that they also have the potential to modify threats and assist with coping. 'Storytelling' and the 'use of humour', described subsequently in this chapter, require the presence of others in order to exist. Despite this interpersonal requirement one cannot deny that they may be very effective in helping the individual to adapt to the situation.

'Storytelling' has been identified by Dingwall (1977) with student health visitors and Davies (1988) with student midwives as a strategy to reduce the sense of powerlessness and anxiety experienced by students during interactions with the medical profession. One incident which had some of the characteristics of 'storytelling' was observed in the labour ward and concerned a student who was complaining about the doctor's behaviour in that area.

> Linda "I was in with a patient once when the S.H.O. waltzed in and said, 'Right, we'll assess you in another hour' and left again. Sister Y went outside and tore a strip off her. She said, 'listen that girl has been looking after this patient and *she* will make the decision on the assessment and how it is handled". (Week 9, Set A, trained 16 months, interview)

Additional comments were also directed at 'sorting out' the doctors and the midwives and making them aware of their 'duties' on the labour ward. During this interaction, the student's perceived inferiority with regard to the medical staff led her to relish a situation

which placed her in a position that she felt was superior to that of the doctor. Such statements, which usually placed the doctor at the mercy of the midwife, or the midwife at the mercy of the student were attempts to redress the balance of power, even if only in the student's mind.

Other 'stories' repeated to me and concerned with midwives' interactions with the medical staff usually involved situations where the midwife had exaggerated her actions concerning how she had or would 'put the doctor in his or her place'.

> Midwife to Susan "Did they leave a mess?" (doctors)
> Susan "Yes, everything, everywhere".
> Midwife to me "I mean that's a bit much isn't it? Its the third time today that's happened. I think the next time I'll just push the trolley out to them". (Week 7, Set D, trained 3 weeks, labour ward)

It is more than likely that in many of these incidents the doctor concerned would not have recognized the interaction if told of it from the midwife's perspective.The telling of tales or threats of punitive action, probably assist the midwife in regaining her self esteem initially lost through a demonstration of powerlessness in front of a student.

Another way of reducing dissonance as a result of conflict with a doctor was to support complaints made by clients about a doctor's lack of skill. Fiona revealed this type of behaviour when a woman complained about an intravenous needle inserted in her arm. After fiddling with it for a moment, Fiona turned to me and said,

> "Its *your* friend and mine who did this". (Week 19, Set C, trained 7 months, labour ward)

A little later when caring for the same woman, who had now requested an epidural, she responded in the following fashion.

> Woman "It won't be the same one (Dr) who put up my I.V. will it?"
> Fiona "No not him — A *proper* chap this time — the anaesthetist".

Fiona had been angry with this doctor, partly because of his treatment of her client, and partly because of his behaviour towards herself. Stepping out of character in not

supporting a doctor when a client had complained about him seemed to her one way of demonstrating that she was not a passive party to his behaviour. It also helped her to redress the balance upset by his superior attitude towards herself and her client.

Dingwall (1977) felt that the telling of stories was a device to redress these types of imbalances in the relationships between people with an unequal power base and also a way to negotiate norms. Stimson and Webb (1975) have also described this behaviour in relation to patients' interactions with doctors. From my observations and my interviews it became clear that a similar situation existed on this study site. However, I would like to go one step further and state that such storytelling has another purpose. It is frequently used as a coping strategy for both midwives and students who feel themselves to be powerless but cannot tolerate the dissonance that such feelings create. To overcome their dissonance they need to reduce the power of the person who created it in the first place. In this study, it was not only a device used by midwives to reduce the power of the medical staff but was also a device used by students to reduce the power of the midwives to an acceptable level. The idea of its use as a coping strategy may, of course, have been implicit in Dingwall's explanation.

8.12.4 The Use of Humour

Storytelling was not the only strategy used by students to convey displeasure with those perceived to be in more powerful positions than themselves. The second most common strategy was to complain about other's behaviour but use humour to reduce the impact. Many complaints about midwives were accompanied by humour, unless the individual was exceptionally annoyed at which time she verbalised anger. The use of humour appeared to be used to place distance between the complainant and the audience as if to say, 'although I'm complaining you can't take it too seriously because as you can see I'm laughing'. Having not identified this before analysing the data I was unable to follow up on these gambits to assess whether the humour would have disappeared if the complainant had received an empathetic response from her audience. An example of this type of strategy came from Peggy, qualified two months earlier and reflecting on the teaching she had received in her programme

> "No, some individuals were very good and some were just--
> weren't interested at all (laughter) with regard to teaching".
> (more laughter) (Week 21, Set A, interview)

Other students in their more senior period complained about their treatment by midwives who attempted to reduce their status by using derogatory names when referring to them. All such statements were interspersed with laughter as the students presented their complaints. One student called over a friend from her set during the interview to discuss the way they had both been treated by midwives who had accused them of having an 'attitude' problem. By the time they had finished reporting the situation both were rolling around with laughter. Again, it is possible that humour has to be used by students who feel helpless in order to reduce the dissonance caused by a midwife's negative behaviour.

In Davies' (1988) study, student midwives were more likely to indulge in self-mockery when placed in difficult or embarrassing situations. While there was some evidence of this with my sample of students they were more likely to poke fun at the midwifery staff and the doctors than at themselves. This difference may have been due to the fact that Davies' sample were asked to keep diaries in which they recorded these incidents. There was no suggestion in her study that this type of humour was shared with others apart from herself. Because I rarely spent time with students gathered in groups of two or more it is possible that such self mockery occurred but not within my hearing.

8.12.5 The Royal 'We'

Another interesting strategy to emerge as an attempt to reduce anxiety was the acceptance of responsibility when students or midwives wanted to complain about institutional practices. I refer to it as the 'Royal We'. Complaining is a method of setting the world to rights along the lines of Dingwell's storytelling and demonstrates to the student herself that she is a beginning midwife, a member of the profession. When the student was not complaining she used the first term of 'I'. However, as soon as a complaint was to be made the 'I' was swiched to 'We'. Again, I think this was a strategy used by students to legitimise their complaint by allying themselves with the people against whom the complaint was being made, as a kind of professional apology.

> Marion "The doctors seeing all the patients in the antenatal clinic — there are examples like that where we're not fulfilling our role." (Week 18, Set C, trained 6.5 months, antenatal clinic)

8.12.6 Use of Technology

The use of technology as a strategy for reducing anxiety was initially a double-edged sword. Technology was seen as something that one must learn as quickly as possible, partly because of the strong emphasis placed on it by the medical profession and the midwives. As a coping skill it could be viewed by the student as a preparation against harm. The lack of knowledge about its use created great anxiety and the students did their best to learn what they could about the machine. This was particularly true of the cardiotocograph because it was imbued with the mystique of saving fetal lives. The very junior students did not take long to assume a dependence on the machine and both they and the medical staff would walk into a room with a labouring woman and look past the woman to the machine. It was interesting to note the behaviour of the women's partners who, after a relatively short period of time in the labour ward, would exhibit the same behaviour upon entering the room. If such role modelling is taken up so quickly by a non-health professional, how much quicker will such behaviour be replicated by the student?

Part of the problem with the use of technology lay in the way it was presented to the students which was very different from the way in which the educators portrayed its use. For the majority of students, it was rarely presented as part of the total assessment of the woman, even though this had been identified by the educators as one of the criterion for its use. Usually, it was presented in isolation as in 'here is the machine and this is how you turn it on'. As Myrtle said,

> "The machinery was pointed out and then referred to for what they used it for. The tocograph and the cardiac--up--whatever--. Not the patient as a whole. Just the particular points of the machine and then the abnormals would be explained to us. But we were never really told enough about the machine". (Week 20, Set B, trained 13 months, interview)

One of the fears the junior students expressed about the labour ward was concerning the technology that was used. Once they had the vaguest understanding of the machine's functioning, it appeared to mesmerise them. Some of the students spent a great deal of time staring at it and, when doing so, would answer the woman's questions with monosyllabic responses. It became obvious to me after a time that the students were using this was another method of distancing themselves from the client which a few students used instead of 'doing the obs'. It certainly appeared to work. The less accomplished

students would stare long and hard at the machine, often not providing any response to a woman who had spoken to them. The woman would then became alarmed about the health of her baby and either lapse into silence or rephrase the question. Many students seemed totally unaware of the anxiety this kind of behaviour provoked in the women.

When discussing this behaviour which she had also observed, Davies (1988) referred to it as 'learning to be taciturn'. Student midwives in her study exhibited such behaviour when they encountered problems for which they felt they had no adequate response. They coped with feelings of inadequacy by saying nothing or very little and waiting for things to improve. This may also be true for these students, though I think stimulus overload is also an explanation. It is also possible that Davies was observing adaptation patterns which were more likely an instinctive response to stimulus overload than an actual learned behaviour.

Lee's (1988) study of registered nurses returning to school in the U.S to obtain a degree reveals some interesting results in the form of coping skills. She attempted to apply the concept of coping as developed Lazarus (1966, 1976) to 111 subjects from two different types of baccalaureate programmes in nursing. One programme had been designed for beginning nurses and provided advance placements for those who had already obtained their nursing registration. The second type of programme was specifically designed to build on the previous experiences of registered nurses. It could be assumed that the two types of programmes might create different types of coping skills because they provided different types of stresses.

The collection of data was achieved through a written description of a stressful incident in the student's clinical or classroom experiences and the completion of a critical incident tool. The latter tool devised by Flanagan (1954) and modified by Walsh and Knopf (1965) enabled students to describe in their own words how they coped with the stressful event. The researcher used precoded categories for analysing the data and used only the first response that the subjects wrote for the category classification. Her codes were identified from the literature and it is not clear how she used two additional coders. It could be assumed that they were used for category verification as she talks of interrater reliablity which she suggests was ninety three per cent.

Lee (1988) found that while all of students used more than one method of coping the favoured method was that of direct action. Eighty two per cent of the subjects used direct

action and 58% used preparation against harm. Attack as a mthod of coping was used in only 8% and 5% used avoidance techniques. Palliation accounted for only 18% of responses. This study is useful in that it provides a closer comparison with the students in this study. Student midwives have, in a sense, returned to school for further education in midwifery after having a career in nursing. There the similarity stops. The subjects in Lee's study only had to deal with a threatening educational experience as opposed to the student midwives' clinical exposure where the potential for harm was encountered on a daily basis.

Conclusion

The work of Lazarus (1966, 1976) on stress and coping was used in this chapter as a framework to understand anxiety and stress in students and their reponses. Research studies using this framework were discussed in the light of their support for the findings of this study.

The majority of the students in this study displayed behaviours on a continuum ranging from stereotypical responses in the early days to an expanded role, when it was permitted, in the later period of training. However, many students felt that their role continued to be restricted by the bureacracy of the institution within which they took their training (Davies, 1988; Robinson, 1989b). Methods used by the institution to reduce the role were generally achieved through the use of policies and supported by some midwifery role models whose practice was constrained.

How students achieved their role competencies depended on the support they received from the midwife and the role prescription they obtained from the Education Department. The role of personality cannot be denied but has only briefly been addressed in these accounts. However, the role of conflict has been discussed with regard to its interaction with stress and anxiety. The creation of conflict as a result of midwives' expectations, behaviour and practices in specific clinical areas has also been considered.

It has been suggested by Olesen & Davis (1964) that a student's previous socialisation to nursing would be a constraint which could interfere with the individual's identification with a new profession. It can provide a constraint by inhibiting the student's options for taking power over someone deemed to be of a higher status. Further constraints, previously discussed, are those of midwives who created a negative image and demonstrated behaviours consistent with a self restricted role. Behaviours of midwives

which indicated powerlessness in interactions also inhibited the students' identification with midwifery.

It is clear that anxiety and conflict are an inherent part of any transition to a new role because of the uncertainty that exposure to new experiences brings. Anxiety tends to be created when the individual experiences a reduced social competence for the new role. Whether the amount of anxiety and conflict experienced by the students in this study was beneficial for the development of competent role behaviours is an interesting question that must be be addressed at another time. I believe a reduction in conflict and anxiety would enable earlier development of appropriate role behaviours and strengthen professional commitment, though a complete lack of anxiety and conflict may interfere with role development.

Most midwives recognised the role of education in providing expectations and definitions for role performance even while identifying the difficulty they had in the clinical area with the 'idealism' of the definition. They also appeared to recognise that role models were necessary to provide the student with a visual representation of the role. What they tended to fail to recognise was that consistency of modelling was necessary, particularly in the junior period when the student had not received a consistent idea of the role. The majority were quite convinced that having shown the student a task a couple of times, they should be expert enough to perform it with little supervision or repetition.

Specific role expectations for each clinical area would probably be helpful for students. However, one must be aware that such specificity could create the very problems about which students are complaining, namely the lack of opportunities to function appropriately within the midwife's role. It was clear to most students and some midwives that the overriding priority on the clinical sites was service and not student education and this will have to be overcome if a positive learning environment is to be achieved.

Communication is a major component of the successful transfer of information concerning a role and the expectations for individual performance within the role. For successful role enactment and commitment to the profession to occur, students require appropriate information in a form which they can understand. The problems that students encountered in obtaining the required information will be dealt with in the next chapter.

CHAPTER NINE

COMMUNICATION FOR LEARNING

In this chapter a link will be made between communication and learning. Communication as a theme was so pervasive throughout the analysis that it was difficult to know where it should be placed in the order. The decision to place it last in the data chapters was made in order that the permeating influence of communication could be better understood. As discussed previously, socialisation to role is a critical factor in any career change and is especially relevant to nurses who undertake a new programme to become a midwife. While socialisation, role behaviour, role expectations and role conflict are vital components in any discussion of role transition the factor which integrates these components and has not been discussed thus far is communication. While it is recognised that communication covers a variety of behaviours, such as body language and paralanguage, this chapter will address only the use of verbal communication for the teaching and socialisation of students (Dickson, Hargie and Morrow, 1989).

It is clear that, without explanation, some aspects of a role would be perceived in a way different from that intended by the role model. Ambiguity in perceptions can also be created through the use of communication which does not contain clarity of information. Misunderstandings over the content of information has started wars and created enemies out of families and friends. Communication is complex and requires an understanding of the context in which information is conveyed as well as a knowledge of the skill required in order to be effective. It can be effective only if the sender and the recipient of the message agree on what the information contains. For many recipients, such as the midwifery students, clarity of the information was a major problem.

Student midwives are provided with observational learning experiences which may or may not be accompanied by explanations of the process involved. If an experience is not explained it is difficult in many instances for the student to fully understand what is happening. Many educational programmes understand the necessity of providing information to aid experiential learning particularly when seeking to create an occupational expertise. The more advanced educational programmes not only recognise the need for theory and practice to be taught in parallel but also the need to integrate them. Unfortunately, it is not always clear what the appropriate method is for such integration to

be effective. In some educational programmes, such as that for midwifery, the need for such integration is recognised and accepted but there appears little effort to ensure that integration occurs in the clinical setting.

The main focus of educational research on human learning has been upon differences among individual learners (Richardson, Eysenck & Piper, 1987). This type of research can only be done if one is sure students have equal learning opportunities in all areas. Such a focus did not provide a useful basis for this study because the study site, by the nature of its service role, was not a stable system providing each student with consistency in experiences and learning opportunities. For this reason alone, it is important to identify what contribution toward student learning is made by the practitioners in the field especially when they are the individuals with whom the students spend most of their time. They are also the individuals who will provide the values and a model of the professional practitioner.

Clinical practice is complex and presents many more realities than can be captured by theory alone (Benner, 1984). In order to understand these realities a student midwife requires an expert practitioner in the clinical field to demonstrate how to deal with them. Learning when to communicate is as crucial as learning what techniques to use (Tomlinson, 1985:17). Unfortunately, midwifery experts in the clinical field have not been taught how to convey information to students and as a result, are often unable to pass on their expertise. In addition, many midwives fail to recognise how much they have learned since they qualified as midwives. Such information has been so refined and codified by the midwife that when it is passed onto the student it is often too cryptic for the student's comprehension. This was observed in the midwives' use of advanced concepts, terminology and cryptic language which could only be understood by a practitioner with the same level of knowledge and expertise. These problems were compounded by the fact that some midwives did not wish to share their depth of knowledge with students because they feared they would lose their advantage and thus their 'face ' before the students.

9.0 Social Interactions

A major difficulty with the interpretation of information passed from midwife to student is an often unrecognised fact that communication is both symbolic and transactional. The sender and the recipient affect each other (Northouse and Northouse, 1985). In engaging

in human interaction through communication, individuals demonstrate how they are related socially and on what level communication will take place. Communication occurs on two levels, content and relationship and is influenced by the desires of the interactants in terms of how much control they wish to exert.

The content of a message itself can be interpreted in many different ways and the exact meaning will emerge as a result of the influences of the interaction. If there is a caring relationship between two interactants then, whatever the content of the message it will be interpreted as helpful. If the relationship is poor then the message will be perceived as unhelpful or possibly even hostile to the recipient. Northouse and Northouse (1985:15) suggest that when there is a healthy interactional relationship the relational aspect of the message recedes into the background and the content becomes more important. In other words, the recipient has no need to analyse the relationship that exists between themselves and the other interactant and search out nuances of meaning in the content which may not exist. In a troubled relationship the opposite occurs. It is unfortunate that these authors do not perceive a need define a 'healthy' or a 'troubled' relationship but leave the reader to assume one's own interpretation of these terms.

A study of the clinical teaching of 311 health care students in the U.S looked at instructor behaviours which most helped and those which most hindered learning from the perception of the students. Being questioned in an intimidating manner was the most frequently identified behaviour to inhibit learning. Jarski et al (1989) adapted a 58 item questionnaire, formulated and tested by Gjerde and Coble (1982) on medical trainees, to obtain information from 311 students registered in eight physical therapy and ten physician assistant programmes. Behaviours found to be the most hindering overall were those classified by the authors as belonging in the interpersonal domain. They suggested that even if the a clinical instructor had good andragogic and communication skills poor interpersonal skills would hinder learning in students.

However, these researchers failed to address the fact that it is not simple to separate out the effects of interpersonal skills on communication. It is impossible to communicate with another individual without allowing interpersonal skills to influence the way that communication is sent and received. Although this is a very useful study for the identification of helpful and hindering teaching behaviours, one needs to be cautious in using such conclusions when they are obtained from a predetermined questionnaire measuring interactional situations such as clinical teaching.

The concept of control, such as that implied in this study, is an integral part of every communication. Some people use conversation, consciously or unconsciously, to exert an influence on their fellow interactants, an influence they may not otherwise achieve. Morton et al (1976) suggest that there are two aspects to such control, personal and relational. In instances of personal control there is a perception by the individual that they can influence the way in which events affect their lives. This increases their feelings of potency about their actions and minimises their feelings of helplessness. This type of control does not have to be exercised or even real to have an affect, only perceived to be present.

Individuals who exercise relational control have a perception that they are able to influence the nature and development of relationships in which they are involved. Control resides within the the interpersonal relationship rather than as a characteristic of the individual. Through communication it is established who is in control, i.e. who is perceived to be the most able to influence the relationship in a given situation.

According to Northouse and Northouse (1985) there are three types of relational control. The first, complementary relationship, exists when the control is unequally distributed as in the case when one interactant is dominant and the other submissive. The authors suggest this is typical of the interactions using the medical model. Some of the instructors in the Jarski et al (1989) study were members of the medical staff and were identified as exercising such a control. Such relationships are stable, efficient and predictable because there is little need to negotiate, everyone knows their place. However, as was identified, it is repressive in that the independence and creativity of the submissive interactant are inhibited. In addition the submissive interactant is rarely pleased with the interactional component of the communication.

This type of interaction was fairly common between midwives and students in this study, with midwives acting out the dominant role and students the submissive. Given the anxiety that students experienced at the beginning of their training and during stressful situations it is possible that students tolerated such relationships because the stability of this type of interaction tended to reduce their anxiety. Once this had occurred they may have found it impossible to change their style of interaction because of the need of the midwives to retain control. It has been suggested that health professionals who function under critical (life or death) conditions believe they require total control over their environment in order to function efficiently (Northouse and Northouse, 1985). If this is true the fact that this

type of behaviour was demonstrated more often in the labour ward would suggest that midwives perceive their work there to be of a critical nature requiring their full control.

The second type of relational control is called symmetrical control. In this situation the control is shared equally between the two interactants and differences are minimised. This can be inefficient, like any democratic power sharing, because of the time required to discuss and negotiate and it can lead to competition between the two interactants. In addition there is the potential for conflict because the individuals involved are often unwilling to compromise their positions. This type of interaction was rare and when it occurred it was practised only by the more confident midwives. With this type of interaction conflict or competition was not demonstrated with the students and only occasionally occurred if the midwives used it to communicate with the medical staff.

The ideal type of communication control is that of parallel relational control. Control is shifted back and forth between the two interactants and results in a more flexible communication pattern. It is less likely to lead to dysfunctional interactions because of the sharing aspect of control. Not all participants wish for this type of communication because it is less stable than the complementary and not as equal as the symmetrical. Although this can result in efficient communication the rules are always changing and it is possible this could create more anxiety in the already stressed individual. Again, a few of the more confident midwives interacted in this way with students but only with those who were fairly senior in experience.

In adition to the relational aspects of communication it has been suggested that communication *is* shaped by the context in which it takes place. Context encompasses the physical location of the communication, psychosocial factors surrounding and impinging on the communication as mentioned above and the affective climate of the interaction and rules which govern the context (Dickson, Hargie & Morrow, 1989). As a result of her study of intensive care nurses Ashworth (1984) has suggested that prolonged stress may affect nurses' communication with their patients. She did not describe how this affect would be achieved and did not provide any evidence to support this statement. She did note that under stressful conditions nurses related more to the technology than to their patients, or exhibited a joking or light hearted manner which demonstrated denial of stress.

Such strategies for coping with anxiety have been discussed in the chapter on anxiety and stress and do lend support to my analysis of the behaviours of student midwives who are

anxious. It certainly lends support to Menzies' (1960) contention that these types of behaviours along with ritualistic and stereotyped behaviours help nurses to protect themselves from anxiety, stress and emotional involvement with patients.

The context, which in this study refers to the clinical areas, could occasionally be an area of conflict between students and midwives. Such conflict occurred when the student expected the midwife to initiate an interaction and the midwife expected the same of the student. If the student did take the initiative with some midwives she would be perceived to be acting out of context and would be the object of some form of interactional sanction. One such sanction, used fairly frequently, was the verbal 'brush off ' given to a student when she asked a question.

For students, the rules governing the interactions were ambiguous. One midwife would practice a parallel relationship in her communications while another would use a complementary relationship approach. For example, the former midwife would encourage the student to take the initiative 'to show interest' while the latter would expect her to be the passive recipient of such an initiative by the midwife. If the student attempted to act in the same fashion with both midwives it was likely that one midwife would perceive her to be behaving in context and would reward her while the other would feel she was acting out of context and punish her for her for her 'forwardness'. 'Punishment' usually took the form of a refusal to answer the specific student's questions. This refusal continued until the student had accepted her 'position' as implied by her subsequent silence. Some midwives found it difficult to deal with any student who did not follow the rules with regard to accepting her 'position'. In such cases the midwife usually absented herself from the student's side as frequently as possible.

9.1 The Timid versus the Confident Student

The ambiguities governing interactions were common throughout the student's training and led to increased stress. Such stress led students who lacked confidence to a decision to 'keep quiet and not rock the boat' regardless of the midwife present or the social situation. This type of behaviour would likely lead to the institution of a complementary relationship in communication between student and midwife if one did not already exist. The student would be perceived as 'lacking interest' and therefore, not worth spending time with for teaching purposes. This was a 'no win' situation for the student. Even for the

confident student who continued to take the initiative there was a problem. This was often greater than for other more timid students who were willing to accept their 'place'.

The confident student was perceived as a threat to the less confident midwives and dealt with accordingly. I observed two senior students from my sample, Linda and Joanne, demonstrating confident behaviour which later became the object of social sanctions. The midwives on their ward had 'meetings ' to which these students were not invited in order to discuss their behaviour and decide on an appropriate course of action against them. The 'behaviour' the midwives did not like had been the independent functioning of these students plus their 'manner', undefined. These students were very confident as individuals and were quite capable of questioning what they saw as the midwives' subservience to the doctors. It was interesting to note that the two students were seen as such a great threat that it required the midwifery resources of the whole ward to tackle the problem. Such situations were rare probably because few students were confident enough to deviate from the expectations held for them by the midwives. However, such incidents did provide evidence of the desire to control 'deviant students' through interactional and communication channels of punishment.

9.2 Communication

Communication in the context of this chapter refers to an individual's verbal ability to interact effectively with others in a professional context (Dickson, Hargie & Morrow, 1989). Effectiveness can be measured in the ability of an individual to transmit occupational or professional information so that learning has occurred in the recipient. However, as Schon (1991) points out, skillful practitioners often give inadequate accounts when asked to say what they do. It is one thing to be able to reflect on what we are doing but a separate skill is required to be able to put our actions into words appropriate for others to learn. This is especially true for practitioners who have not been taught such skills.

The value of teaching communication skills to health workers has been identified but is only now filtering into the health professional's education system (Faulkner, 1980; Macleod Clark, 1981). Therefore, the midwives in the clinical area had not been taught these skills when they trained as nurses and such skills were assumed and not taught during midwifery training. There was an assumption held by the Education Department and the service side, that midwives, having been taught skills by other midwives when they

themselves were in training, had subsequently acquired the ability to perform the same function with students. If the midwives complained about such assumptions and declared themselves not ready to teach they were themselves treated as 'deviants'. It was assumed by management that such midwives were attempting to evade their responsibilities because they felt threatened by the knowledge base of the students. The students' knowledge was assumed to be more current than that of the 'deviant' midwives and thus would expose the midwives' paucity of knowledge of current practice. This was felt to be the reason for the midwives' reluctance to teach and it was rare for sympathy to be extended to them. It was even rarer for such concerns to be valued in the light of a professional not wanting to teach because she felt unprepared for such a function.

Dingwall (1977) suggests that individuals maintain control over communications through their and other's sense of stratification. This ties in with Dickson, Hargie and Morrow's (1989) idea of a contextual influence on social interactions. The provisions of stratification ensure that only one member may legitimately perform an action at one time. The problem of gaining access to the floor for the purpose of communication is solved by placing control over such access in the hands of one member. This member is usually someone with the highest status in an interaction. In Dingwall's study, it was the tutor who had access because she had a higher status than the student health visitors. Dingwall noted that when the students had sessions with social workers, who they perceived to be of a lower status, they would negate this access by collecting together notes, shuffling their feet and sorting out their coats as the end of the session approached. It was observed that this type of behaviour was not demonstrated by students during sessions with doctors.

Stein (1967) described some aspects of indirect communication between doctors and nurses as attributable to personal security which was affected by the status of the individuals involved. He suggested that successful interaction between doctors and nurses depended on the nurse making the appropriate recommendations without appearing to and the doctor being able to ask for suggestions without making an overt request. This saved 'face' for doctors who were not supposed to require advice from the nursing profession because nurses were lower in status. These strategies were achieved through each person attending to non-verbal and cryptic verbal communications. Stein believed that the basis of nursing and medical training provided the way in which nurses and doctors learn to bring off a successful performance in these types of interactions. When the performance is not successful because one or both of those involved fail to follow the rules, conflict can

occur. Conflict can also occur between students and midwives, as previously described when the same rules are not obeyed.

Verbal communication is perceived by some to be a way of controlling access to the profession. The professional has a special knowledge and in return for access to that knowledge she is accorded a mandate for social control with regard to matters which relate to her expertise (Schon, 1991). Some midwives were seen to exercise this control either deliberately or otherwise, through the use of terminology, inappropriate communication strategies and non-responsive measures to student questioning. All of these methods represent the use of control over the content or the relational aspects of communication.

9.2.1 Inappropriate Communication

If the acquisition of role depends upon the use of language to convey the appropriate message to the recipient then the use of terminology and abbreviations can only interfere with the process. Terminology and abbreviations were found to be used frequently in interactions with students who were often not sufficiently advanced in their training to find them helpful. An example of such terminolgy used to answer a very junior student's question is provided by the following,

> Martha "Why did they do a forceps?"
> Midwife "For P.E.T." Martha looks puzzled.
> Midwife notices this, "Pushing with a high blood pressure can be detrimental for the patient". (Week 19, Set E, trained 3 weeks, labour ward)

Although there seemed evidence during this interaction of the midwife's desire to communicate effectively with the student it did not happen. The midwife had picked up, via the student's body language, that learning had not occurred and attempted to remedy the situation. Due to a lack of knowledge of what was required, a misunderstanding of the student's level of expertise or a lack of communication skills the midwife was unable to facilitate the learning process in an effective fashion. During many similar interactions I was not always able to ascertain whether the fault lay with the midwife's lack of communication skills or an attempt to guard information. For some midwives I suspect the truth lay somewhere in between. It is also possible that some midwives did not recognise their need to dominate by reducing the content of the communication to the student.

Interactions between doctors and patients are known to demonstrate a guarding of professional knowledge and this was evident in this study. Guarding of information during communication is one method of keeping the recipient of the information in a submissive condition. When students were present during such interactions, which of course occurred in most clinical areas, they were provided with a role model for the control of communications with clients.

> Dr. "I think we'll get you in to check your sugar — come in for a few days — could be 'a light diabetic'. If it was just your blood pressure would send a midwife in to check it but because of sugar — want to make sure everything is alright."

In the above situation the client had come in for what she believed to be a routine antenatal check. She was provided with information which indicated that she could have a problem of which she was unaware. However, the information was given in such a way that the student had to first calm the woman down and then explain what the doctor meant after he had left the room.

One of the problems of pregnancy is that conditions which appear as a result of pregnancy, such as gestational diabetes, rarely provide physical indications to the woman that her pregnancy is not progressing in a normal fashion. As a result, the information provided by the doctor in the above interaction was insufficient for her needs and would be likely to create anxiety. I am sure the purpose of the communication was not to create anxiety but to provide information while still retaining control. Some students and midwives were aware of this problem with medical communication and sought to reassure the woman with more information during the interaction or after the doctor had left the room. However, if the midwife used a similar pattern of verbal interaction to the one described above and observed in the majority of the doctors in this study, then the student was at risk of being socialised into the use of similar communication patterns which emphasised control.

Rosenfeld & Hanks (1980) observed of nurses and patients that 'information represents power in the struggle for control and is thus a pivotal question in the study of negotiated order'. Strauss et al (1964) identified the concept of negotiated order as that employed to account for changes in the social order through enactment and negotiation. Strauss (1978) later emphasised processes, such as negotiation, coercion, manipulation and persuasion as

primary in analysing social structures between organisational systems. However, all of these processes require verbal communication and such communication can be used to manipulate for control.

Not only was information withheld for controlling purposes but it was also withheld as a result of constraints brought about by unit policies. Some midwives found it difficult to explain to women the policies for medical intervention in labour and delivery, particularly when they did not agree with them which was often the case. As a result, the midwife often explained the desired outcome rather than providing the woman with choices because of constraints she felt were laid upon her by such policies. An example of such a situation on the study site was a policy on the labour ward which required that a woman's membranes be ruptured when her cervix had dilated to 2 centimetres. Quoting the desired outcome (from the medical point of view) did not provide the woman with a complete explanation nor did it provide her with choices for childbirth (Kirkham, 1989). Such a situation was clearly demonstrated in the antenatal clinic.

> Woman "Can I go now?"
> Marion "No, you have to wait and see the doctor".
> Woman "Why?"
> Marion "Because you're 32 weeks". (Week 4, Set C, trained 3 months)

In his book *Educating the reflective practitioner*, Schon (1988:16) states the following, 'Students learn by practising the making or performing at which they seek to become adept, and they are helped to do so by senior practitioners who initiate them into the traditions of practice'. In line with this reasoning in order to initiate learning of skills the teacher or facilitator must use language as a method of communication for the initiation. Communication skill is regarded as the ability to use the means of communication effectively with regard to the needs of those involved (Dimbleby & Burton, 1985:58). This means that for communication to be effective it must provide the student with information which facilitates her learning. Students were often more likely to recognise this fact than were the midwives.

> Martha "You find here that you're just another student and usually they don't know where you are in your training and so sometimes they give you too much information and you don't understand it and you can't cope with it". (Week 55, Set E, trained 10 months, interview)

It can be seen from the literature that rearchers such as Dewey (1966) have long supported the fact that the right kind of 'telling' can assist the student with the learning process. The right kind of 'telling' or communication is an important factor in any form of socialisation to a new role. Goslin (1969:10) stated many years ago that the acquisition of language skills was a prerequisite for learning most roles and facilitated the learning of other skills for role acquisition. This has not changed but it has been slow to be recognised in a general sense and even slower to be implemented in some areas of health education.

In Kirkham's study (1987) of midwives' interactions with labouring women she found that while midwives recognised and supported the need pregnant women had for information they rarely provided it in a form which was useful or explanatory for the women. This information was required by the women in order for them to cope with an experience that many had not previously undertaken. Glaser and Strauss (1967) described this lack of information as being due to the overriding importance of the 'sentimental order of the ward'. This order is defined as 'the intangible but very real patterning of mood and sentiment that characteristically exists on each ward' and appeared to be a crucial source of staff security which they did not wish to see threatened.

Such an explanation would seem a trifle simplistic to accept for this study especially as many midwives really perceived themselves to be providing the women with the amount of information which they required for their present circumstances. For instance, if asked about pain control by the woman the midwives would usually provide her with information about the type of pain relief most frequently used or, if the woman had already made a decision then she would provide information on that decision. At no time that I observed did the midwife provide the woman with choices of pain relief and the advantages and disadvantages of each but when questioned, did not perceive herself to be withholding information.

Such a situation was observed in an interaction between a midwife and a woman in labour who was actively seeking information.

> Woman "No one's talked to me about the labour and I'm really scared especially after that programme on T.V. on Sunday — put you off labour for life".
> Midwife "Any idea what you want? You can squat or anything". (Week 20, labour ward)

Here, the midwife was eliciting information while providing very little in return. Of course the woman did not ask directly for information from the midwife in case she was rebuffed. Therefore, the woman sees herself in a vulnerable position for which she required a face-saving manoeuvre. The student, who was present, observes such tactics and consciously or otherwise must take such behaviours on board. Whether she practiced them herself is another issue but in many instances this was observed to happen.

Some students were perceptive enough to be angry with the midwife over these types of exchanges. Despite this, few felt strong enough to challenge the midwife but would try and fill in the gaps with information after the midwife had left the room.

> Woman "I feel really tired and had a spot of blood 2 weeks ago. Also had mastitis, which was really painful, while I was feeding Graham".
> Midwife "So---Graham going to nursery school?" (Week 9, antenatal clinic)

A few students were even able to extrapolate from the similarities of the midwife-client interaction to the interactions between themselves and their midwives. Such extrapolations were only obvious to students who were close to completing the course. The fact that many students, particularly those in the junior period, were heard to be using inappropriate communication strategies, would suggest that this type of role modelling had achieved a modicum of success.

Both Macleod Clarke (1984) and Faulkner (1984) noted similar communication behaviours in nurses using what they referred to as 'closed' or 'leading' questions with their patients. This type of questioning was used with the patient to direct the conversation where the nurse wanted it to go. Again, this is an example of relational control using a complementary strategy to avoid getting involved in the patients' problems which are often of an emotional nature. When 'open' questions were used and information elicited they were rapidly 'blocked' by the nurse. Macleod Clark (1984) suggests that the purpose of 'open' questions was merely part of a ritual the nurse indulged in and not to elicit information which would be helpful to the patient.

Blocking techniques used by nursing staff in both studies were; the use of humour to 'joke off' the question, the avoidance of a patient's question by asking another question, or the use of inconsequential chatter to distract the patient from pursuing a response. There was

no mention of a failure to respond to a question by maintaining silence and this could be due to the restrictions inherent in the use of recording equipment without the benefit of direct observation. Macleod Clark (1981) found in her analysis of video and audiotapes of nursing interactions with patients on surgical wards in three different hospitals that neither the busyness of the ward nor the number of staff on duty affected the amount of verbal interaction provided to patients by the nursing staff. Both she and other researchers have found that nurses talk very little to patients and only about technical details or their tasks (Faulkner, 1984; Ley, 1982).

9.2.1.1 Verbal Asepsis

Kirkham (1989) referred to the restricted type of information given by midwives to women in the labour ward as verbal asepsis, a term originally coined by Sheila Kitzinger (1978). Kirkham's use of this terminology was confined to women who were given the verbal 'brush off' as documented above. I expanded this category to include the verbal 'brush off' in all instances where I felt insufficient information was provided for the needs of the clients and the students.

The information was considered restricted when it did not provide the content requested by the woman. An example she provides from her research is as follows,

> Patient "I don't know about the epidural. What do you think?"
> Sister "Lets see how it goes". (Week 9, labour ward)

The behaviour Kirkham described is the same type of communication 'blocking' behaviour audiotaped by Macleod Clark and obtained by Faulkner through the use of interviews with students, staff nurses and ward sisters. This would suggest that once these behaviours are learned by student nurses they are retained persistently throughout their career and into the next career in midwifery. Students are most likely to adopt modelled communication behaviour if it results in an outcome that is rewarded or valued (Bandura, 1977). The behaviour of some midwifery sisters on this site would lend credence to Bandura's statement.

During my observations of student midwives on the labour ward, I found a very similar type of information exchange occurred.

> Woman "I won't feel anything? Won't be able to push?"
> Sister "Right. Want to leave you an hour and then we'll get you to push". (Week 15, labour ward)

This woman had received an epidural anaesthesia and was still seeking information on how this drug would affect her ability to have a spontaneous, vaginal delivery. Although she received an answer to her question it was short and to the point and did not provide her with the information that she was seeking, in an indirect fashion.

The reason for the discussion of the above situation is that the constraints applied to giving information to labouring women by midwifery staff appeared to equally apply to students. A student seeking information from a midwife with regard to infant care received the following responses.

> Lynne "Three-hourly obs.? What about breast feeding then?"
> Midwife "Yes----may need a bottle. Got haemolysin?"
> Lynne "What's that?"
> Midwife "Extra enzyme----took blood". (Week 23, Set E, trained 6 weeks, postnatal ward)

The midwife answered the question but did not in this instance provide enough information for a junior student, such as Lynne, to know what she was talking about. It is difficult to know here, as in previous situations, how much of the poor communication can be attributed to guarding of information, lack of knowledge of how to provide information or lack of awareness with regard to communication skills and the student's information needs. The midwife did appear to be interested in supplying the student with information but at no time did she assesss the student's level of comprehension.

In similar situations, this type of communication was observed to be due to a lack of sufficient knowledge for teaching purposes. Assessing the learning of the student could lead to more questioning of the midwife and had to be avoided if she could not provide the answers. As a result, the midwife attempts to protect herself from a 'loss of face' in front of the student with such strategies. As in Kirkham's (1987) study both the students and the newly qualified midwives were aware of their lack of knowledge and sought to avoid exhibiting this fact to the client through the use of blocking strategies learned from other midwives. However, Kirkham did note a difference between clients of different social

classes. Those women who appeared more knowledgable, e g. upper social classes, were likely to receive more information than those who were hesitant in their questioning, such as those from the lower classes.

However, while the communications provided to the students and the clients were of a similar nature, this cannot be said for student and client communication with the midwife. The client rarely asked the midwife a direct question preferring instead to phrase it in an indirect fashion in order to save herself from a possible rebuff This behaviour was also noted in patients in other studies (Faulkner, 1984; Macleod Clarke, 1981). In this regard the client accepts the mandate of the midwife to have control over the knowledge she transmits to the patient and her own lack of power in gaining access to such information.

The students did not feel themselves subject to the same mandate and usually requested their information in a very direct fashion.

> Janet "Anti-D given in 72 hours, right?
> Sister "Right". (Week 9, Set B, trained 9 months, labour ward)

In the above situation the student received the exact information she requested but no more and she had to persist in order to obtain it. The sister made no attempt to ascertain whether the student knew what she was doing or even what she felt the rationale was for giving this injection at such a time. A similar episode in the labour ward emphasises this point.

> Midwife "Now she's had her epidural take her B/P every five minutes."
> Violet "How far on is she?"
> Midwife "6 centimetres"
> Violet "How long will she be?"
> Midwife "Not long". (Week 19, Set C, trained 26 weeks)
>
> or
>
> Marion "Does a woman who is feeling fine and 32 weeks need to be seen by a doctor?"
> Midwife "Yes. Shared care?"
> Marion "Yes".
> Midwife "Right then". (Week 29, Set C, trained 9 months, antenatal clinic)

The students above were more senior than the student in the next example which may have been the reason why the more junior student did not use such a direct approach. She may have felt that as a newcomer she had not yet obtained the right of access to professional information and as such, was able to ask for information only in a less than direct fashion. In this incident Susan had been worried about the baby's heart trace.

> Susan "It's still the same."
> Midwife "Who's her doctor?" (Week7, Set D, trained 2 weeks, labour ward)

In the midwife's case there is a rationale behind her question which, depending on the seniority of the student, the student may or may not recognise. The midwife was ascertaining who the woman's consultant was before determining what course of action to take. Each consultant required a different action plan for specific problems. However, if the student was unable to recognise this she may perceive the midwife to be avoiding a response to her question and guarding information. If this becomes the student's perception she will then look elsewhere for her teaching needs. Few students felt confident enough to repeat a request for information especially those in their junior period.

Many of the students perceived the midwives and medical staff to be deliberately keeping information from themselves and their clients. Acknowledgment of behaviours, such as guarding of information, enabled the students to be angry on behalf of their clients without identifying that such treatment of themselves revealed a lack of respect for their student status.

> Ginny "They didn't explain about the A.R.M. Sister said they wouldn't rupture her membranes because of her section scar and then she ruptured them. She never explained". (Week 5, Set B, trained 9 months, labour ward)

Guarding of information by providing insufficient facts for the recipient to arrive at the same conclusion as the provider of information was a common form of manipulation and control and was observed frequently with regard to midwives' interactions with clients and students. This strategy of information restriction was observed to be interspersed throughout many of the interactions between doctors and clients, doctors and students, midwives and clients, and midwives and students. It was also observed between some of the students, junior more often than senior and between students and their clients.

Many students felt that the guarding of information was particularly bad on the labour ward as revealed by lack of communication and body language,

> Florence "You are often excluded when the report is handed over---totally as a student. I have had to push myself forward and say, 'I need to hear this too----and we are never included in decision-making". (Week 22, Set D, trained 5 months, labour ward)

Observations of student-midwife interactions on the labour ward supported such complaints. One such incident occurred on night duty when the night sister came in to give the report on the woman's progress to the midwife. The report began with the sister speaking in a very low voice and the student on the opposite side of the room. The student crossed the room to join them but had to lean forward to hear because the sister and midwife were standing with their backs to the room and leaning over the cupboard. At no time did the midwife check that the student was cognisant of all the facts concerning the woman for whom she was providing care.

Students who were too timid to push themselves forward without an invitation were often not included in the handover on the client's condition and would have to request the pertinent facts from the midwife afterwards. Even in situations where the student was the primary care taker of the client, the midwife was very sparing in the information she provided on the client's condition. In such cases, not only was verbal language restricted to exclude the client and the student but body language was used as a barrier to students who did not conform to expectations. For many midwives, a student was expected to conform and wait passively to be instructed and provided with the amount of information deemed suitable for her to receive.

Students who did not conform to the expected pattern of behaviour were excluded in the way described above or left in the room with the woman while the report was given outside. It was a very controlling situation in that the student had to then request more information which was provided grudgingly in a piecemeal fashion. This situation occurred only on the odd occasion and only when an insecure midwife was faced with a confident student. It is interesting to note that while the midwifery profession seeks independent practitioners who can formulate decisions without the assistance of the medical profession, such people are penalised when, as students, they exhibit the desired behaviour. There appears to be an ambiguity within the midwifery profession towards the role of the

midwife and it is possible that its roots lie in the present system which supports nursing as the main entry into midwifery education. The socialisation processes of nursing were originally calculated to produce a conforming individual who 'knew her place'.

Other methods used to keep the students in line were such strategies as telling the students that they were not ready for the information for which they were asking or the common one was to suggest it was too soon to be provided with certain information because the student was too junior. All of the students recognised these as strategies although most were reluctant to accept that they might be methods for guarding information. Most preferred to believe that it was because the midwives had never been taught how to teach and therefore, it was not their fault. This may be due to an already developed sense of identity with the profession and a resulting inability to criticise its members. However, one or two of the more disillusioned students felt that such strategies were due to lack of knowledge and confidence on the part of the midwife.

> Linda "I always listen to what they say (midwives and doctors). I often think it's not enough and think what I would say and depending on the midwife, I'd add something". (Week 8, Set A, trained 16 months, interview)

Midwives who had trained outside the study site and those who had finished training fairly recently were the ones identified most by the students as lacking in knowledge.

The fact that some midwives used verbal asepsis to control information appeared to be reflected in many of the students' interactions with their clients. One woman who had just delivered her baby obtained the following response for her question.

> Woman "Do you think he'd want to get up and feed?"
> Maureen "How're you going to feed him?"
> Woman "Breast feed".
> Maureen "Do you want to do your teeth?" (Week 18, Set C, trained 26 weeks, labour ward)

The students' reasons for blocking questions was often due to their lack of knowledge although their previous role models may have played a part in producing this behaviour (Kirkham, 1987). If they were not able to produce the behaviour required by the client

they attempted to change the subject. In this exchange, Susan provides the main reason for blocking behaviours.

> "I've stopped asking women if they have any questions because I feel so stupid when I don't know the answers". (Week 11, Set D, trained 7 weeks, antenatal clinics)

The comment above reminded me of an anecdote told to me by a doctor who had recently graduated. He said that while a student, he and his colleagues would read up on a patient's history in order to provide him/ her with the information they required. They would then rush into the ward, ask the patient questions, give the information recently obtained and then rush out of the ward again. This strategy was performed to convey to the patient that they were knowledgeable but were too busy to answer questions. The doctor felt the strategy was very successful because the students was never exposed to the patient as having a limited knowledge. Such strategies as this were common with students and midwives alike. If the student did not arrive with the strategy in place it did not take long for her to acquire the skill.

Students did demonstrate the use of verbal asepsis not only to control information but also through what appeared to be a genuine desire to get to the root of someone's problem.

> Susan "What's your blood loss like?"
> Woman "Terrible".
> Susan "How often do you change your pad?" (Week 13, Set D, trained 8 weeks, post natal ward)

Susan was attempting to find out whether the frequency of times the woman changed her pad was related to her perception of her blood loss. To someone not functioning on the same level of expertise the question was mystifying and appeared unconnected with the woman's response. This may be one of the reasons that many consumers feel that health professionals are not communicating with them. Not only do many health workers not have the required communication skills but also they are pursuing different objectives from those of their clients. This type of communication has been identified as an efficient method when used with individuals who have the same level of expertise but not for those, such as patients and students, who do not (Benner, 1984).

9.2.1.2 Auditory Asepsis

Developing further Kirkham's (1989) idea of asepsis, I believe there are two separate processes occurring with restricted communication and propose the term 'auditory asepsis' to separate the incidences where minimal information was given from those where no information even though it was requested. Kirkham did not separate out the categories, referring to all interactions in which minimal or no information was forthcoming as verbal asepsis. I prefer to separate them out to allow for situations where midwives may not have responded to requests for information because the request was not heard. I think it is fairly obvious from the anecdotes provided that, as with verbal asepsis, the midwife, student or doctor had heard the request for information but had chosen for various reasons not to respond in the appropriate manner.

With auditory asepsis, no response was forthcoming but it was not always clear whether or not the request had been received. It is possible that the midwife had heard the request and had chosen not to respond because either she did not have the information and preferred not to make the client aware of the fact, or she used her lack of response as a form of control. A lack of response may also have occurred because the midwife felt that the requested information was not the type to be overheard by a client because it was of too personal a nature. However, other than asking her afterwards if she had heard the request for which I may or may not have received a truthful answer, I felt it necessary to give the midwife the benefit of the doubt.

It was not always clear when the woman requested information in an indirect fashion whether the midwife recognised it as such a request. If she is not well versed in communication skills and covert meanings, it is likely that she will not. The client, however anxious, did not appear able to phrase the question in any other way.

> Woman "He (the baby) doesn't look at all squashed. I think with all that pushing around he'd be really squashed?". No response from the midwife.

This woman had had her baby delivered by forceps and was quite clearly concerned about the effects on her baby. She continued for some time to request reassurance in this indirect fashion but appeared unable to alert the midwife to her needs. It was left to the student to recognise eventually what was going on and to attempt to reassure the woman as she transferred her to the ward.

On occasion, when information was requested by a student, I felt the omission of a response to be deliberate, but it is impossible to support this definitively. In the anecdote described below, the student is attempting to assess a different method for giving an oxytocic preparation.

> Mabel to midwife "Couldn't we just use the drip?"
> No response from midwife
> Mabel "I suppose—no. I suppose its best to just give it?"
> Midwife "Yes". (Week 21, Set D, trained 4 months, labour ward)

It appears fairly clear that auditory asepsis could have been a strategy used in this instance to encourage the student to reflect on what she is asking and provide her own answer. If so, it was obviously effective as it achieved the desired response. It was not a strategy that was used frequently or, if it was, it was not recognised by me, perhaps because it did not usually have an effective outcome.

Auditory asepsis was not a common strategy for midwives to use except as mentioned earlier as a form of control. However, it was used fairly frequently by the junior students and some senior students and usually was related to their level of knowledge and expertise.

> Woman to student "Why are you feeling my tummy?"
> No response from student (Week 25, Set E, trained 5 weeks, labour ward)

Students had other strategies for brushing off questions from women that were used more frequently and will be described later.

9.2.1.3 Maxims

Differences between what are perceived to be incomplete or complete communications could also be blamed on what Benner (1984) described as maxims. The term was first coined by Polyani (1958) to refer to a form of shorthand or cryptic instructions used between professionals, such as expert nurses. Expert nurses learn much from such communications but it only makes sense to the recipient if that person has a deep understanding of the situation and the same level of knowledge and or experience.

As Benner describes it, this type of communication is used to convey a lot of information in a short time and is ideal when the communicating parties are at the same level of expert skill and understanding. Many of the midwives used this form of communication for the same reason and as a result it was most evident in the delivery suite and the clinics where time was at a premium. Unfortunately, many midwives communicated in this fashion with the students particularly when they were under pressure to complete a task quickly.

The senior students were often able to decode some of the information provided in this way but the junior students were, as could be expected, totally lost. However, few of them felt confident enough to tell the midwife that that they did not understand. The few that did, soon changed their behaviour as they were often left with the feeling that their lack of comprehension meant they were stupid. This feeling was not necessarily created by the midwife but by their own feelings of inadequacy. They felt that as nurses they should have been able to decode such information. However, this is unrealistic for, as Benner (1984) points out, even expert nurses will have problems if they are transferred to a place with different requirements from those in their place of expertise.

In the following example the use of maxims along with codims or terminology was used,

> Sister to junior student "Some type 2 deccelerations but this pattern is normal in late first and early second stage".
> (Week 9, Set D, trained 2 weeks, second day in the labour ward)

Mandy, a slightly more senior student was also somewhat puzzled by the following remarks which took her some time to decode.

> Sister watching the C.T.G trace "Has so many hypotonic contractions — 4 to 5 minutes — resting phase — then active phase". (Week 4, Set C, trained 3 months, labour ward)

This same student was later heard to say to a woman she was caring for,

> "I hope you can manage to walk around — get the baby's head in the right place — not so painful".

Midwives were rarely observed using such communication patterns with their patients although the use of terminolgy was consistent throughout. However, this was probably because I was observing the students and not the midwives. One such incident was recorded in the community.

> Sister tells the woman that her baby is cold.
> Woman "That's because the baby wasn't properly dressed because I was getting her ready for her bath".
> Sister "Yes, I realise that but you see the head lets out a lot of heat". (Week 15, Set D, trained 10 weeks)

Though midwives did not use maxims frequently when communicating with clients students did often, and it was used by some to convey their status to their clients and by others, to reduce the number of questions they would be asked. Even when asked questions, they used the strategy to discourage any further attempts by the woman to retrieve information. This strategy was used more commonly in the antenatal clinic where women had the time to ask questions and the expectation was that such questions would be answered.

> Midwife to student checking an antenatal patient. "Urine O.K?"
> Marion "Just a trace of protein".
> Patient "What does that mean?"
> Marion "Just a bit of discharge". (Week 4, Set C, trained 9 weeks, antenatal clinic)

A similar example was observed with a student checking an intravenous infusion of dextrose inserted into a woman's arm. The woman was concerned about air in the tubing which connected her to the infusion. She expressed her concerns to Bronwen.

> Janet "Don't worry ----need a good length of air". She laughed, and then walked off. (Week 5, Set B, trained 9 months, labour ward)

9.2.1.4 The Blind Approach

This term has been coined to describe communication patterns which did not fit into any of those described earlier. Schon (1988.27) noted such patterns of communication between teachers and students in an architectural course. In the incident he documented he described the teacher as following a 'strategy of mystery and mastery'. The teacher asked

the student many questions in order to evaluate the problems the student was having with a design. However, the teacher kept to himself the meaning underlying his questions and did not connect the questions with how he wanted the student to perform. Any criticism he made the student saw as a direct attack and defended herself accordingly. The teacher did not invite the student's inquiry into his meanings nor does he inquire into hers. As a result they appeared to be going around in circles each missing out on the meaning involved.

> Janet "I often didn't know what the midwives were talking about unless they got a book and demonstrated it. They would ask us questions but I didn't understand what they meant. Students were often grouped together so in the early days it was too advanced and I just got lost". (Week 53, Set B, qualified 4 months, interview)

Whether one can refer to such patterns of communication as maxims is debatable. I believe that a 'mysterious' interaction, such as that described is due to many factors, not least those of poor communication and a lack of awareness of the needs of the student or the client. In the incidents I observed, there rarely appeared to be an attempt to deliberately misdirect either the student or the client. The whole process seemed more related to two individuals pursuing separate but often parallel paths to achieve the same objective. The client wished to be fully informed about her body, her progress and the progress of her baby. The midwife and the student, with the same objective in mind, pursued different strategies which left the client confused and with unmet needs.

This 'blind' strategy was pursued when the midwife, student or doctor responded to a question with a question. One might describe it as a maxim because, without prior knowledge of the situation the doctor, midwife or student would be unable to learn from such questioning (Benner, 1984). One might also describe it as a form of verbal asepsis because the woman is not 'expert' enough to obtain information from the questions she is asked. However, the 'blind' approach to communication seems a more appropriate title because while such behaviour was observed many times in the the clinical area, none of the health professionals appeared aware of the anxiety such a technique created in the recipient.

9.3 Student Communication Patterns

Many of the students were genuinely concerned about their clients and often derided both the doctors and the midwives for providing them with insufficient information. When possible, the students themselves filled in the gaps for the client after the midwife or doctor had left the room, not aware that their communication behaviour followed along similar lines. Myrtle was a case in point. Like most of the students she was a very caring individual who would have been horrified if she had realised what message she was conveying to the patient. She like others was able to see the lack in the midwives' or doctors' interactional skills, but not in her own. The example below was observed in the labour ward and amply demontrates this phenomenon.

> Myrtle to patient "We're going to put a clip on baby's head — attach it to the machine so we can hear the baby's heart". (Week 22, Set B, trained 13 months,labour ward)

or

> Sister to Bronwen (talking over a woman in labour) "Blood pressure alright?"
> Bronwen "Yes. Came down after the epidural. So did the F.H". (Week 5, Set B, trained 9 months)

A similar example was overheard with a sister talking to a labouring woman.

> Sister "Open your legs — if you don't you are going to strangulate the baby — alright?"

or

> Doctor "The baby is facing the wrong way at the moment. The largest part is trying to get through the narrowest point. We'll put a suction cup on the head and pull it out".

It is not surprising given such role models for communication that students used the same form when interacting with their clients. However, as mentioned earlier it was also possible that the students were not providing more complete information because they had no more to give. This was certainly the case with the junior students who tried to 'fit in' by attempting to communicate the very limited information which they did have. As a result, the information provided was full of terminology recently learned without a rationale

which would have enabled them to answer some of the women's questions. It was also information unchanged by the learning process because incomplete learning had taken place and was passed on in that context. There was little recognition that the client had even less of a knowledge base than they themselves. Sometimes it was used by students as a controlling strategy to convince clients that they had a greater knowledge than they actually possessed.

Midwives sometimes used terminology with students and clients to control and reduce the amount of questions they asked. It was unclear whether the midwives were conscious of the use of such methods. As Kirkham (1989) found with the midwives she studied, both they and the students recognised the need to provide the women with information. Many recognised that the medical staff were very poor in this area and felt that part of their role was to fill the gap left by a lack of medical information. My observations also demonstrated that students and midwives really believed they were providing full information to the women and were, in the main, not aware of the discrepancies in their communication.

Students were not the only ones who liked to 'fit in'. Once the majority of doctors found out why I was in the labour ward their method of interacting with students changed. Where previously they had scarcely noted the student's presence they now began to teach. Such teaching incorporated the use of language that contained few codims or maxims. They appeared to be aware of the need for simpler language in order that the student could obtain the maximum benefit from their teaching.

The doctors were not informed that I expected them to teach students but they were aware that I was observing who taught students' clinical skills. The only reason I can hypothesise for their change of behaviour is a social one, such as not wanting to be perceived as the one person who was not 'doing their job'. This behaviour was not so obvious in the midwives probably because it was an expectation that they teach the student. The change in behaviour could also have been due to a lack of awareness that they were not doing the job until they became aware of my presence.

9.4 Appropriate Communication

A number of midwives were efficient in their teaching of skills to students. Efficiency was determined by the provision of information which was complete enough to not only

provide the student with the knowledge concerning the skill, but also the rationale for when and why the skill should be performed. In the main midwives who provided such teaching had not received formal teaching instruction from such courses as the P.G.C.E.A. (post graduate certificate in education of adults) but were viewed by the students as 'natural' teachers. It is possible that they, like their less efficient colleagues were simply emulating a role model, one who had provided them with appropriate communications when they were a student.

> Midwife to client and student "What's happening now is that the baby is reacting to the drip or to the labour so I'm going to get the doctor in to see". (Week 12, Set D, trained 3 weeks, labour ward)

Successful midwives also expressed an interest in teaching which was not always evident in their less successful colleagues who usually provided reasons for being unable to fulfill such a role. One of the sisters on the labour ward provided three reasons for the poor teaching practices of midwives; lack of interest, guarding of information and a lack of awareness of what they had to offer students.

> Sister "Not everyone is interested in teaching. Some people are just interested in their own clinical practice and are not always keen to share it. I also think a lot of people possibly have knowledge that they don't realise they have and don't realise that other people would appreciate getting it from them". (Week 7)

Further communication strategies for keeping the students in line were those which minimised the student's status. Some of the consultants used these strategies with midwives as well as students. Instead of referring to a midwife or student by name or title he would refer to her as 'girlie'. This was by no means common to all of the consultants, just those who seemed to want to put distance between themselves and the staff. However, for others, I believe it represented an attempt to be friendly but with an inability to identify what title would be most appropriate. I observed only one consultant who took the time to read the names off the student and midwife's badges and call them by name.

One or two midwives were not adverse to using such strategies to control students. Some students had been referred to by such individuals as 'plebs'. This infuriated them especially as most felt incapable of 'telling off' the individuals concerned. Many of them felt

frustrated and angry and one of these was Ginny (Set B). While recognising that the problem lay in the midwife's lack of confidence in her interactions with the student, Ginny remained angry. The reason she gave for her anger was the fact that although the midwife was younger than her she still felt unable to tell her how much she disliked being called such names. Her vulnerability and lack of control over the situation fuelled her anger and kept it going for several months after she had ceased working with the midwife concerned. Indeed, Ginny was one student who identified herself as returning to nursing when she had completed her training even though she had entered the programme wanting to be a midwife. She appeared unable to articulate how much her perceived treatment at the hands of the midwives had affected her decision. However, I did note that she was one of the few students who had experienced problems in her community placing. Such problems were caused by her refusal to stay in the residence when on call for community and differences of opinion with her community mentor over her mentor's practice.

The midwives who bothered to call the students by their given names and did not indulge in the use of insulting titles were, needless to say, perceived in a more positive light. Such midwives were seen as 'teachers' even when they failed to give adequate explanations to the students. Any discrepancies in communication with these midwives were blamed on the system and its lack of preparation for such individuals. One midwife was perceived in a positive way by junior students because of the support she provided. She had the following to say.

> "When students are referred to in a derogatory way I think it gives them the the idea that they're here to do menial tasks. On this ward a student is given a set of people to care for and they're expected to do everything for them. But not extra things for other people". (Week 25, Set A, qualified 7 weeks, postnatal ward)

The lack of appropriate information given to students by midwives not only slows down the learning process but also produces midwives who feel neither competent or confident in their skills. In addition, the student who has been exposed to this style of teaching will almost certainly use it when she herself is teaching students. An information deficit combined with body language which conveys hostility and a guarding of information is quickly received and understood by the student. This results in the student seeking her information from elsewhere in some situations, for example other students, which may lead to perpetuating errors in practice.

When questioned, many midwives claimed to evaluate the verbal learning needs of students. Students stated that this rarely happened. It was interesting to note that while it was rare for this to occur in the early days of my observations, the frequency of evaluation of certain clinical skills, particularly those specific to the labour ward, increased as the study progressed. However, it still tended to be only the confident midwives who evaluated knowledge through communication. It is also true that, as suggested by some midwives, students were often unaware of when they were being taught or evaluated. For some students, teaching had to be prefaced with the appropriate words or placed in the right context for them to be aware of this fact.

Teaching was identified as being conducted on the labour ward and in the special care baby unit but rarely on the wards. Many students were more likely to perceive themselves as being used for service purposes on the ward, than in the labour ward. This may have been related to the excitement of the labour ward and the fact that many of the tasks there required the direct supervision of the midwife which was often not forthcoming. How frequently the midwife was present at the student's side was directly related to the student's perception of learning. This was a fact that many midwives were aware of but failed to address.

The nature of the special care baby units also necessitated a nurse or midwife in close attendance. However, this unit was active in the teaching of skills to nurses on the E.N.B. 405 course and the staff were felt by students to be more interested in their development as a result. The antenatal clinics fell into a category all by themselves. They were perceived not only as poor in teaching students but also as poor in not fulfilling the midwife's role and therefore provided only poor role models. These problems were compounded by the fact that the skills required here were those of communication and teaching. There was little that students could 'do' physically. They had to interact with clients and it was in this situation that their knowledge base was exposed to the client as incomplete. Whether the problem for students was verbal asepsis, maxims, codims or auditory asepsis it was perceived by the students as poor communication which, for whatever reason, interfered with their learning.

> Ida "I mean sister was not really communicative and the doctor was not communicative---they didn't even tell the patient anything". (Week 5, Set B, trained 9 months, labour ward)

Summary

Communication patterns used by midwives in socialising students to their roles were found in many instances to be inappropriate for teaching purposes. The contexts in which the students were taught affected the types of communication patterns used. On the labour ward, verbal and auditory asepsis were observed to be in fairly common use along with maxims as teaching strategies with quite junior students who failed to comprehend their meaning. The 'blind' approach to teaching was prevalent on all units and the use of maxims was the main problem on the special care baby units.

Complementary relations were used most commonly in midwife-student interactions as a form of control. The less confident midwives felt a need to demonstrate to the students that they were the dominant force in any teaching interaction. A great deal of human behaviour is motivated by the need to reduce anxiety whatever the cause (Bandura, 1977). Taking on a new role such as that of student creates anxiety and fear. Therefore, using communication behaviours which are implicity rewarded by the system as well as reducing anxiety will ensure that those behaviours become part of the students' repertoire. Once adept at such behaviours students will perform them whenever they feel threatened and these will be maintained because of their success in reducing aversive events. Once established they are difficult to eliminate even when the threat has been removed. Students who become nurses are likely to carry over these behaviours into their professional career as nurses and subsequently midwives. Midwives who communicate with clients in this fashion will be unlikely to change their style when communicating with students especially if the same complementary relationship exists.

It would appear that in order to share control in a communication interaction one would require empathy. Empathy is a complex process which requires an individual to enter the perceptual world of another temporarily living their life without apportioning judgement (Rogers, 1975:4). It may involve different processes such as observational skills, communication and perceptual skills, emotional sensitivity and caring. It is required for a helping relationship such as may exist between student and midwife. It is also possible in the present stressful climate of the hospital that many factors, such as shortage of staff, poor staff communications and bureaucracy, inhibit empathy.

Midwives and medical staff were observed to use asepsis and maxims as strategies to control clients and students and induce them to conform to staff expectations. They were

also used by staff and students alike to prevent clients from becoming aware of the limitations of their knowledge. The 'blind approach' did not appear to be a conscious strategy for avoiding the provision of information but nevertheless led to client and student dissatisfaction because of unmet information needs.

Teaching communication skills to students and nurses does not address the underlying problem. Communication strategies are used by students, nurses and midwives to protect themselves from an emotional involvement with their clients. Without such protection the outcome of such involvement may be 'burnout'. The withdrawal of these protective mechanisms may require that other support strategies be in place before communication strategies can be fully utilised for the clients' and the students' benefit. The last chapter will present the conclusions of the study.

CHAPTER TEN

FACTORS AFFECTING THE AQUISITION OF CLINICAL SKILLS

This chapter summarises the study and identifies the key concepts or themes which emerged from the data. Implications for midwifery education are discussed and recommendations are offered. The limitations of the study are discussed.

10.0 Summary of Study

The ethnographic case study design used in this study was chosen in order to identify significant contextual interactions between students and others which promoted the learning and acquisition of clinical skills and competence in midwifery. The principles of grounded theory were used for obtaining and analysing the data. One of the aims of the study was to provide an understanding of what is involved in assisting students to acquire clinical midwifery skills. It was hoped that by analysing this data, presenting the concepts and conclusions regarding the processes involved, one would gain an understanding of the processes of socialisation and learning in midwifery.

A brief history of midwifery was provided because it was felt to be relevant to the present functioning of midwives. One such relevant factor was the medical profession's continual attempt to dominate midwifery. A review of the literature on the major concepts of socialisation in midwifery was not presented because of the absence of research in this area. This was one of the reasons for the use of a qualitative approach to this study.

A cross-sectional sample of twenty five students was obtained from a large, urban maternity unit. Observations of the students in the clinical setting were carried out over a period of eight months, along with formal and informal interviews. Midwifery staff and educators were also interviewed over a period of fourteen months.

An eight week exploration of the clinical environment, which I made as a participant observer prior to the commencement of the study, suggested themes such as anxiety, poor communication, and poor supervision of students These themes were observed to emerge from the study along with others identified during the analyses.

The majority of midwives who were expected to teach students in the clinical area had no training in teaching clinical skills with the result that many failed to provide the appropriate content, supervision, evaluation or feedback on the student's performance. These deficits were exacerbated by a lack of awareness or understanding of student learning styles and requirements. It was difficult to identify more than two student learning styles, active and passive, because the majority of students attempted to 'fit in' to the clinical area by conforming to the requirements of the staff. 'Trial and error' was the most common strategy used by midwives when allocated to students often because they subscribed to the myth that one had 'to do' in order to learn. The more confident midwives who were perceived by students to be 'natural teachers' appeared to recognise the need for more teaching support and creative visual strategies to help students learn.

Anxiety had a major inhibiting effect on all of the students but was the most disabling with those in the their junior period. In the latter group of students it tended to lead to 'thought blocking' behaviour which was demonstrated by their inability to attend and react to stimuli in the clinical area to which they were expected to respond. A limited amount of 'thought blocking' behaviour also occurred in senior students when they were exposed to a new clinical environment, such as the special care baby unit which caused extreme anxiety. Such behaviour prevented students from learning new skills and assimilating new ideas concerning their clinical role. It continued until the students had adapted to their environments and their anxiety had decreased.

The major response of junior students to anxiety was to 'do the obs', a stereotypical response from their nursing training. This behaviour was not expanded into a midwifery assessment until the students became more comfortable with their environment and their role. The senior students became angry when anxious and used humour and 'storytelling' in an attempt to redress the balance. Despite these techniques many of the students continued to verbalise anger from anxiety-provoking situations which had occurred many months earlier. The focus for most of the anger was the labour ward where many students felt they had been left unsupervised with women in labour for long periods of time.

Both junior and senior students complained of the lack of supervision and teaching support, but midwives on the whole felt that what the students received was adequate. What constituted supervision was identified in different ways by midwives and students. Midwives felt that being close by in another room provided the student with supervision. The junior student wanted the midwife by her side while she was practising her skills. Senior students

felt they were too closely supervised, but not necessarily taught in their senior periods and were not provided with enough responsibility for decisions concerning the care of their clients. Community midwifery was viewed in a positive light by students because it provided one-to-one teaching, continuity of care and close supervision.

A factor which created conflict in the student was that the Education Department presented the midwife's role in an idealised fashion which was perceived as 'unrealistic' by the service staff. Because midwifery educators spent little time in the clinical area this problem was not addressed. Both the midwives and the students felt that the educators were needed in the clinical area to assist with the teaching of students and to help midwives keep up-to-date with current practice.

Prior socialisation to nursing was felt to be a key factor in the difficulty with which students obtained midwifery clinical skills. Such difficulty was compounded by the fact that students had previously had responsibilities as nurses which made the transition to the student role more of a problem. This was not helped by the midwives in the clinical area who treated students as service staff of little value rather than imbuing their role with an educational and professional perspective.

Students had to go through a period of deconstruction of their role in nursing before they were able to actively learn and assimilate the clinical content of the midwife's role. It is possible this deconstruction was influenced by the midwives' treatment of them. A conflict in the midwives' expectations resulted in their use of students to provide nursing service while not validating their previous status, knowledge and experience in nursing. The lack of a consistent midwifery role model with whom the students could identify during their clinical rotations left many students feeling fragmented in their learning experiences.

Many of the problems students experienced with learning clinical skills and decision-making were created by inappropriate communication from the midwives and the medical staff. Communication often took the form of verbal and auditory asepsis and maxims. Guarding of information was observed to be an interactional style of some midwives when allocated to students and similar behaviour was observed occurring between doctors and their clients.

Medical staff, particularly those at the level of consultant or registrar, often provided teaching opportunities for student midwives. Midwives in the antenatal clinic abdicated their responsibility to students for teaching skills by directing them to the medical staff. Such

teaching was often used as a reward by these midwives when the students had 'completed their work'.

Poor organisational support for the student role was observed in terms of 'trial and error' learning, little structure in the clinical area for teaching students clinical skills, and their inclusion on the duty roster as part of the service staff. Shortages of staff, unit policies and medical interventions combined to interfere with students' learning and obtaining competency in midwifery skills.

10.1 Discussion of Major Findings

i. Socialisation and the Learning Process

Socialisation and learning are closely interrelated in that learning is required in order for socialisation to be effective. Learning the requirements of a role whether it be occupational or social requires that an individual learn the values, attitudes and expectations of the role along with the expectations of significant others for that role. These attributes must then be internalised in order for the individual to be committed to the role. Previous role conceptions, obtained prior to entering the role, can reduce the impact of socialisation to the present role and possibly inhibit the internalisation of values and attitudes required to obtain a commitment to the profession.

The process of socialisation in the police academy was seen by Van Maanen (1973) as a deliberate effort to change the recruits' unrealistic expectations of their new role. The field training officer was the person made responsible for introducing the recruit to his real role on the street. A somewhat similar situation occurs in nursing when the student nurses spend their initial weeks in the Education Department but clinical socialisation is undertaken by the ward staff. Midwives also were given the responsibility of socialising students to their role and they used a number of strategies to obtain this end. The initial strategy was to reduce the status and the value of the students' previous career in nursing. In addition students were expected to provide service with little explanation or rationale provided for the choices made in the care. Skills were taught sufficiently to make the students 'safe' in their midwifery care but not to encourage a questioning attitude. If students demonstrated the propensity to question the midwives they were rebuffed with silence or an inappropriate response. Police recruits or police officers were also punished if they questioned the organisation (Heidensohn, 1992; Van Maanen, 1973). Indeed, both the police recruits and the student

midwives quickly learned that passivity was an organisational value and it was better not to be noticed.

For an occupational role there are professional skills to be learned in order to be successful in the behavioural aspect of the role. However, the organisation administering the hospital follows its own bureaucratic goals in the type of specialised skills it requires of inductees. Little recognition is given to the professional midwifery aspects of the occupational role. It is clear from the literature that such socialisation practices have achieved some success in reducing the professionalisation of some health workers' roles. Both Simpson (1979) and Windsor (1987) found that the emphasis placed on skills acquisition by the hospital changed the nursing students' idealistic notions and emphasis on helping to a concern with skill acquistion. The use of job descriptions, policies and procedure guidelines on this site suggest that the hospital hoped to achieve an homogenised effect with its midwifery staff with safety of the client as the overriding factor. It is also possible that hospital organisations do not feel able to cope with the conflicting demands of the medical staff and the midwives. As a result they support the more powerful group, the medical staff, in their constraint of the midwife's role. This may be one reason why hospitals with few medical staff allow the midwives more freedom to practice their professional role (Robinson, 1985).

Van Maanen's (1973) study of police officers and Pavalko's (1971) description of the military suggested that work-related relationships are formed by inductees in order to overcome anxieties created by idealistic conceptions which conflict with the reality of their new role. The same held true for student nurses (Davis, 1983; Simpson,1979; Windsor, 1987). If the socialisation of student nurses can be extrapolated to student midwives, then students need work-related social relationships in order to overcome their previous conceptions of role. Whether or not organisations have the maintenance of peer relationships as their goal their socialisation processes often created this outcome (Pavalko, 1971; Van Maanen, 1973). It is possible that the organisation sees this as a positive outcome in maintaining a group with common values and attitudes which favour the organisation. In Simpson's (1979) study student nurses sought out patients as significant others with whom to relate during their clinical experience. Later the students' focus switched to colleagues and other health professionals who became important in mirroring how they were progressing in their role. In Davis's study student nurses saw other students, staff nurses and the ward sister as people to whom they could address their concerns. Teaching staff were not important sources of support in either study.

It would appear from this study that the staff in the Education Department abdicated their responsibility in supporting a professional orientation for the students in the clinical area. The lack of a teacher's presence on the wards left students exposed solely to the hospital organisation's socialisation practices. The methods of teaching provided by the midwives were often inappropriate for the establishment of role-related and professional behaviours. Not only was there a difference between the philosophies of education and service but the goals were not the same. Educators expected students to be able to practice and take on responsibility immediately upon graduation and in doing so to adhere to the values and attitudes of the profession. Service staff expected the student to give safe care and to adhere to organisational policies which were often in conflict with the values of the profession. This hospital, like most organisations, did not seek to create an autonomous professional but someone who would not raise problems in the functioning of the organisation (Pavalko, 1971). To a certain extent some of the midwives supported the hospital in this philosophy.

It is possible that student midwives initially have difficulty identifying significant others because of their recent change in career. They will have developed support relationships with others who shared the same nursing career. If these relationships are maintained the student will be exposed to new experiences which she may find diffficult to share with her nursing friends. In addition the maintenance of nursing relationships may reduce the effect of midwifery socialisation. This was not an aspect on which I focused except where such interactions occurred on the units. Students did seek out their peers but only when transferring clients from the labour ward to the postnatal ward. Discussions at these times usually referred to the type of experiences each student had been exposed to on that day especially with regard to the number of deliveries obtained on the labour ward. These discussions would suggest that the emphasis the organisation places on the acquisition of skills has been absorbed by the student. In addition these skills are a requirement for qualification as a midwife.

Students who had previously been socialised to nursing were observed to experience difficulty with the learning of clinical skills required to practice the role of the midwife. Prior socialisation and learning could inhibit the uptake of clinical skills in midwifery by creating a resistance in the student's mind to new information. This resistance was demonstrated by the use of stereotypical nursing responses, such as 'doing the obs' or 'thought blocking' behaviour to most clinical situations (Davies, 1988). This would support Bandura's (1977) suggestion that a great deal of human behaviour is motivated by the need to decrease anxiety. Once this behaviour has been found to be successful it is used whenever the

individual feels threatened. As a result of this study I would conclude that student midwives have to unlearn some of their previous nursing and status behaviours before taking on a new midwifery role and a reduced status

Reilly and Oerman (1992) state that the educator is important in legitimating the student's role. The professional self image created by the student is a reflection of the reactions of others who legitimise and ratify it. If the image that is reflected by the midwives is restricted to that of a service orientation then the student will be exposed to a conflict between her perception of her role and that which is reflected back to her. When midwifery teachers do not appear on the wards the students' professional and educational role is not legitimised.

Olesen and Whittaker (1968) noted that in the absence of educators in their study students used the researchers to legitimise their role. I was used in the same fashion on this study site with students often appealing to me for elaboration and teaching on concepts they had just discussed with their clients. Students often sought me out and would come and fetch me when they were moved to another place. In addition they would seek my support for skills they had completed which they felt they had performed well. Although Davies (1988) did not state this specifically or address this issue, from the anecdotal information she provided it was clear that students sought the same thing with her through their interviews and in their diaries.

Socialisation to a new role is a process in many occupations which appears to follow a defined path. This path may vary somewhat dependent upon how much support is provided and the continuity of that support for the inductee. Nursing students originally identified ward staff from whom to seek support and guidance during their first year of training, especially with regard to finding out about the 'job' (Davies, 1988). In the police force the continuity of a field training officer acted as a buffer between the new recruit and the 'street' and this appeared to help recruits adjust to their new life. Student midwives in this study were not provided with a continuous role model and therefore experienced considerable 'reality shock' as a result of the discrepancy between their anticipatory perceptions, which were supported and maintained by the educators, and the 'reality' of life in the clinical enviroment.

A problem in the training of midwives in high technology maternity units was the increasing emphasis placed on technology and high risk care. This represented the undervaluing of 'normal' noninterventionist midwifery care. Midwives are by definition

providers of care to women who experience a normal pregnancy, labour and puerperium. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help (International Confederation of Midwives,1972). In high technology obstetrical units this has been translated into care provided through the use of technology and medical interventions. Technology leads to increased use of specialisation by the organisation to maintain control (Pavalko, 1971). This was noted on this site because midwives worked in only one area of expertise, such as the antenatal ward. This has devalued and restricted the midwife's function to a supportive role for medical staff. Therefore, the student midwife who comes with the expectation that she will be functioning independently in providing midwifery care may find herself acting the part of an obstetrical nurse. This is an obvious cause of conflict which is difficult to resolve in these types of units.

The use of technology, policies and medical interventions within the institution inhibited students' learning of midwifery skills by placing constraints on their learning opportunities. The institution had a hierarchical form of administration and this appeared to produce a student who conformed to the status quo for learning behaviour regardless of her previous learning style. Shortage of staff may have promoted a 'trial and error' style of learning which provided little time for students to reflect on the information they had obtained. Some students felt that learning in an institution which emphasised medical intervention and technology would not help them to feel confident working in a different type of environment.

It was observed that midwives who were confident in their skills were creative in their endeavors to teach skills to students and provide them with the appropriate amount of information, supervision, evaluation and feedback on their performance. In addition, these midwives placed little emphasis on technology as part of their practice. Such midwives taught midwifery skills and, when possible, provided reflective time in the form of debriefing for students. Midwives did not have to demonstrate an expert knowledge in order to present students with a positive role model but they did need to provide an accepting and flexible image which allowed students to negotiate their role. For most students the midwives' lack of knowledge pertaining to student needs, learning styles and level of role development inhibited the effectiveness of their teaching. This lack of preparation has been noted to occur in other occupations.

It would appear that other occupations place little value on the needs of the inductees during training, preferring instead to focus socialisation practices on the needs of the organisation. Heidensohn (1992) found that when the police department decided to integrate women police officers into the same department and work as the men neither the men, nor the women were given training in preparation. This was despite the fact that the men had no idea what the women had previously been doing (child abuse and junvenile crime). The women felt very undervalued by the system. Additionally, upon entry into training, both the women and the men were very shocked by the militaristic tones of the socialisation process (Van Maanen, 1973). Initiation into the occupation had not been changed despite the fact that the process had originally been created for men only. Heidensohn felt that the women were treated poorly when they were reprimanded for questioning the system. She did not seem to be aware of the fact that the same held true for the men.

For the police women, entry involved rites of passage into a new separate world and status which was totally masculine and made no allowance for their gender. All of them had to face questions about themselves and their role because they were women. There was no true permanent static adaptation rather a series of negotiated strategies. Forms of abuse and hostility along with rumours and gossip were forms of social control of women. They had to do exceptional work to prove themselves and this happened each time they gained a promotion. The women felt they could undertake the work but were influenced by the values of the department on what was 'real work' and valid experience. There are some similarities here with midwifery. Although midwifery is a predominantly female profession the medical climate in control on this site was essentially masculine. Midwives were constantly challenged on the more autonomous aspects of their role and there was little support from the senior midwifery staff for any midwife who challenged the status quo. Social sanctions were imposed on midwives who attempted to question their role in the organisation and although not abusive, could be emotionally disturbing. Some midwives, like the policewomen espoused the values of their role while submitting to the dictates of the hospital administration.

ii. Communication

Appropriate verbal communication is necessary for learning and socialisation to a new role. Individuals being socialised to a new role learn a common language and a shared set of interests which help to attach them to the organisation which they are entering until they have their own experiences (Van Maanen, 1973).

An inductee needs clearly defined and uniform expectations in order to become commited to a role. There is a need for those who know to share their knowledge about the job and expectations with inductees and allow them the freedom to act out the role that suits their need (Brim 1966). In Van Maanen's study this information on the culture and 'the job' was passed on by field training officers who provided continuity of practical experiences and determined the time and place when the recruit would face their first challenge on the street, such as making an arrest. For student midwives clear expectations were not forthcoming because each midwife had a different set of expectations for the role. Student midwives were 'thrown in' and expected to learn the 'job' as they worked. There was no continuity to the socialisation process and students were not prepared in a graduated fashion to cope with the challenges of the role. They were expected to cope with crises and challenges as they occurred. If their actions were deemed inappropriate by the midwives they became the subject of social sanctions or a reprimand.

Unfortunately, the need for control of information and of interactional relationships led some midwives to guard information. Evidence of this was seen in the use of techniques, such as verbal asepsis and maxims when communicating with students. It is not clear how unconscious was the use of such techniques. For junior students the information transmitted by such techniques was incomprehensible, but some of the more senior students were able analyse its content with some skill. It was clear that verbal asepsis, maxims and closed questioning were techniques used as a method of control by some midwives and this has been noted in studies of nurses interacting with patients (Faulkner, 1980; Macleod Clark, 1981). It was also clear that students adopted this behaviour, consciously or unconsciously, and used it when interacting with clients. However, the decision of when to use it appeared to be related to the amount of confidence the student had when interacting with the client. In interactions with the midwife the student usually used maxims in order to convey that learning had occurred.

iii. Anxiety

Anxiety and fear in the inductee are often the result of a lack of knowledge concerning one's role and the socialisation process. Anxiety, as a result of a concern with the rules for task performances, has been noted in student nurses exposed to their first clinical experiences (Windsor, 1987). Anxiety appeared to initiate coping behaviours that made the student seem unreceptive to new information on midwifery. This continued until her anxiety was reduced by her familiarity with her environment and the staff's expectations. To become more receptive the student may also need to deconstruct her previous nursing role in order

to reconstruct the role of the student midwife. Deconstruction of the nursing role and reconstruction of the midwifery role would be enhanced by a consistent, midwifery role model able to demonstrate continuity of care. Reconstruction would probably be better supported by the presence of the educators in the clinical environment to legitimise the professional midwifery role. Such legitimation is also required for students to feel as if they are learners and not just nurses giving care. Midwifery staff on the units did not provide this because they tended to perceive the student's role principally as providing service.

Appropriate and complete communication has been shown to reduce anxiety and have a positive effect with patients (Johnson,1973). Johnson found that telling patients prior to surgery how they would feel afterwards as well as providing them with some coping strategies helped to reduce their anxiety and pain. Students stated that their learning was inhibited when midwives did not provide them with sufficient information to make decisions about care. The fact that they were taught by midwives with little education in communication and teaching skills was identified by them as a problem. Students also observed that those midwives insecure with their own clinical skills used various verbal strategies to keep information from them.

The use of inappropriate types of verbal interaction along with social sanctions for breaches in role behaviour, such as questioning the midwife, may have been to counteract the students' idealistic expectations (Pavalko, (1971; Van Maanen 1973). Inductees' early perceptions of a new occupation in which they expect to be treated as an equal and participating member can be altered by submissive and degrading experiences. Although student midwives were not subjected to physically abusive socialisation experiences the method of withholding information and the derogatory comments addressed to them by some midwives left them feeling very anxious and degraded. Being placed in clinical situations for which they had received little verbal or skill preparation increased their anxiety and enhanced their feelings of isolation and loss of control. Midwives did not perceive their treatment of students as being harsh and were most likely modelling behaviour they had been exposed to as students. Indeed, this type of behaviour was no different to that which midwives used with their clients (Kirkham, 1989).

To cope with the anxiety, student midwives brought into play strategies which resembled those used by student nurses. When anxious, junior nursing students related back to their lay image in an attempt to overcome their fears, and they continued to do this even though there was evidence that it failed and created frustration and disappointment (Davis, 1983).

Junior student midwives also harked back to their previous role in nursing to remind themselves of the status and responsibilities they had once held. As with the student nurses, the student midwives continued to do so for some time despite the fact that such reflection identified the discrepancies of status between what they were and what they had become. This identification often increased their anger at the midwifery staff.

The amount and continuity of support provided by midwifery staff appeared to affect the students' anxiety and their commitment to the profession. Many things can interfere with support. One factor is the pressure of the delivery of a service under extreme time and manpower restrictions. Such can affect nurses' behaviour and thus influence the role expectations and behaviour of student nurses. It can also cause the rejection of the more professional orientation taught in the school for one of expediency and least resistance (Olesen & Whittaker, 1968; Simpson, 1979). These conditions obtained with the midwives on this site and it was clear that both the midwives and the students suffered as a consequence. Under these circumstances the midwife is forced into a conflict to meet differing expectations of service and education.

Midwifery students did not assume their new professional role until after they had qualified. Van Maanen found that police recruits did not feel they were policemen when they first emerged from the academy and worked on the street. This may be due to the fact that until they are given the responsibility to make decisions they cannot fully internalise the role. Somewhat similar findings were noted in Becker's et al (1961) study of student physicians. The majority of these students felt ill-prepared to act as doctors upon graduation because the hospital had provided them with little opportunity to practice being responsible for decision making. In this study student midwives close to qualification felt ill-prepared to function as midwives on any site other than this one. Even here they felt concerned as a result of the lack of time given to practice in an autonomous fashion. Students were treated as students up until the day they received their qualifications. In addition the controlling methods used by the midwives to restrict information led to a dearth of knowledge and experience in making decisions. Students and educators recognised this problem but there was little attempt during this study to solve the problem.

10.2 Theoretical Propositions

Individuals entering different occupations undergo similar processes of organisational socialisation. This includes methods to reduce the idealistic expectations with which they

enter and strategies to 'homogenise' individuals so that they espouse the same values and non-questioning attitudes. It is hypothesised that the intensity of the methods used is a factor of where the occupation is placed on the professional scale.

Midwifery, like other occupations, does not fully socialise its inductees to their role, especially its teaching aspect. Typical of a semiprofessional context, the socialisation process of the organisation in which student midwives work conflicts with the values espoused by the profession. This conflict is ongoing because theoretical and clinical education are provided concurrently. Additional conflict is created in midwifery students who have previously been socialised to a nursing career. This also creates difficulties in learning the skills required to become students and midwives. Conflict can be reduced by positive role models who have good communication and interactional skills and provide continuity of modelling. This, along with appropriate teaching, supervision, evaluation and feedback by midwives along with the use of reflective time was observed on this site to reduce anxiety and enhance learning.

When the institutional values conflict with those of education then some midwives will take on the values of the institution to reduce intrapersonal conflict. While teaching students these midwives will experience anxiety because of the conflict with the student's professional perspective. In an effort to control this midwives will use interactional and communication strategies to restrict the student's role and functioning.

Since this study was completed there have been changes made in recognition of the importance of mentorship for student education. Student midwives are placed with mentors who work with them consistently and evaluate their skills. There are now courses for both nurses and midwives which assist them in identifying student needs. E.N.B. 997/998 for nurses and midwives was a newly introduced teaching/assessment course which enabled nurses and midwives to be aware of the needs of the student. Midwives are assessed at the end of the course on their interactional and teaching skills with student midwives. This course began after the completion of my study on this site.

In addition there has been the initiation of 'Project 2000' in nursing which enables students to be socialised to their profession in a non apprenticeship educational system. This system provides a general theoretical basis for nurses at the diploma level and they specialise in their chosen career only after an initial eighteen months has been spent on a Common Foundation Programme whose key orientation tends to be a social science as well as

nursing contexting of health and prevention. Although the midwifery profession rejected 'Project 2000' there has been a determined attempt in many midwifery schools to upgrade students from a certificate to a diploma level and provide a greater theoretical input into midwifery education. Both of these programmes remove the student from the bedside and provide an educational grant instead of a salary. This removes the emphasis on service as a major component of education.

It is not clear how much emphasis has been placed on the teaching of communication and interactional skills at the diploma level but it is noted that many of the new degree programmes contain courses in communication skills (personal communication Macleod Clark, 1990). There has also been an increase in the number of midwifery schools providing direct entry midwifery programmes with some providing a degree. Several midwifery graduate programmes have been initiated, one of the first by the Royal College of Midwives in collaboration with the University of Surrey. Again, it is not clear how much course content is addressed to the need of midwives for communication and interactional skills at this level.

Many hospitals have instituted team midwifery to provide continuity of care and reduce fragmentation. This approach provides students with a more positive experience of midwifery and better continuity of clinical experiences. It also reduces the emphasis on technology and 'high-risk maternity care' and increases the emphasis on 'normal' midwifery.

There has been some movement toward the founding of midwifery-led units in hospitals. These units would establish midwives as the primary health professional in the care of women in prenatal, intrapartum and postnatal care. Midwives would be responsible for all decisions on midwifery care and doctors would be consulted only at the midwives' request.

10.3 Limitations

This study was limited by several factors. The time constraints prevented the full use of grounded theory approach and thus the saturation of all the emerging categories. Therefore these categories have been presented in the form of theoretical propositions instead of a grounded theory. It would have been more useful to have had a comparison case study site which did not encompass the medical model to the same degree in order to better identify the effects of medicalisation on midwifery. It is possible that on such a site midwives would be less inhibited by a medical presence and feel more free to teach their professional skills

and values. It is also possible that only the more confident midwives work on sites with a reduced medical presence and the result of reduced medical interventions would lead to more midwifery-oriented care.

My perceptions are likely to be different from those of another researcher because of the different types of formal and informal socialisation experiences we have undergone. My experiences will also have an effect on my analysis of qualitative data. Therefore this study would have benefited from an analysis provided by another researcher particularly with regard to the identification of emerging categories. Ethnography is complex and dependent upon a number of strategic choices and the active construction of the environment according to my view of 'reality'. This construction is affected by decisions on what details I will include and what I will omit. As Van Maanen (1988) says, ethnographic detail is presented by the researcher on the Doctrine of Immaculate Perception. While I do not claim this distinction, I do believe I have provided as truthful as possible, albeit a somewhat biased account, of 'reality' in one English midwifery training hospital.

10.4 Recommendations

Based on the results of this study the following recommendations are offered:

1) All midwives should receive some teaching in communication and interactional skills. Without this it is difficult for them to be either effective teachers or effective care givers.

2) Midwives need contining education on effective teaching and evaluation of students. This should involve an understanding of the student's prior socialization to nursing and a validation of the worth of their previous career. Such an awareness needs to encompass an understanding of the anxiety experienced by students when faced with a new environment and a new career.

3) All students should be provided with a consistent midwifery role model who can remain with them in their rotation through several clinical settings. Such mentors should be chosen on the proficiency of their skills and their comfort level with teaching students. This will entail choosing mentors with at least one to two years of post training experience.

4) It is suggested that direct entry of students into midwifery be encouraged. This should make it easier for students to acquire clinical skills because of less need

for deconstruction of a previous nursing orientation. However, this will need to be carefully researched in the light of Benner's (1984) findings with student nurses.

5) Midwifery teachers should be present in the clinical areas, for the support of students and midwives, on a regular basis.

6) Midwifery teachers should provide the clinical areas with a synopsis of the students' knowledge base and objectives for that clinical area and the concepts to be learned. Heims and Boyd (1990) suggest that objectives should be written specifically for concepts to be learned in the clinical area in order to focus learning and reduce the concern with learning tasks. This approach would provide more holistic learning and would encourage the integration of theory with practice

7) Hospitals or maternity units should encourage midwifery teaching by including the educational component as inherent in the normal work load of the ward staff.

10.5 Future Research

The results of this study suggest that communication is being used in a self protective way by student midwives and midwifery staff. Research is needed into ways of teaching effective interactional skills and strategies which can replace the protective communication mechanisms used by midwives. One study noted that 60% of students indicated the most inhibiting effect to their learning was the poor interactional and communication skills of their clinical teacher (Jarski, Kulig and Olson, 1989).

Other case study sites with a reduced medical presence or a more egalitarian approach to maternity care should be investigated for the type of socialisation practices they use to teach professional skills and values. It would also be interesting to identify whether team midwifery does provide a better professional model for student midwives and increase their professional commitment. Another useful research study would be a comparison of students in direct entry midwifery programmes with those who have entered midwifery from nursing on the efficiency of learning and socialisation.

One of the major findings of this study was the pervasiveness and debilitating effect of anxiety in students. Little research has been addressed to the identification of anxiety in midwifery students and its effect on learning and professional work. Such research should

focus on methods of reducing anxiety through healthy coping strategies which students may continue to use in the midwifery profession.

With the new approaches to diploma teaching and a non service status for students there should be an ongoing evaluation of the effects of such change. These programmes should be investigated for whether they reduce the anxiety of students and provide a more professional orientation. It is possible that with the removal of students from the bedside there is a increased risk of 'reality shock' if the values provided by education are too unrealistic for transference to the clinical environment. A quantitative study examining this possiblity would be helpful.

Conclusion

This study demonstrates the value of indepth observations and interviews in examining a clinical area of complex interactions . An ethnographic case study approach to the collection of data was extremely helpful in identifying how the hospital culture provides students with their impressions of midwifery. The use of the principles of grounded theory enabled me to identify concepts which may not have been discovered using other methods. The ethnographic approach along with the symbolic interactionist basis of qualitative methods provided me with an understanding of the intricacies of human interactions, emotions and adaptations which obtain in a clinical apprenticeship situation. To be successful such apprenticeship requires students who are motivated towards midwifery as a career and informed individuals who are motivated and proficient in teaching clinical and professional skills.

Limited organisational support for the student and professional midwifery role resulted in some midwives seeking to control interactions with students and clients through the use of various communication strategies. This effect was compounded by midwives who had adopted the bureaucratic values of the organisation at the expense of the values of their profession. These midwives sought to restrict students' learning through the control of information. The professional socialisation provided by the educators was reduced and in some instances, destroyed, by their lack of support of student midwives in the clinical area and their legitimation of the student role. The lack of support provided by some managerial midwives for professional decisions on client care has led some midwives not to question the status quo.

The Second Report from the Health Committee (1992) on maternity services states that:

> "there is an established need for professionals involved in maternity services to address the issue of providing women with a wider choice of place of birth and to consider ways of organising services to support that choice. More immediately, there is a need to establish ways of providing a choice of a less medicalised pattern of intrapartum care, whatever the setting" (para 230).

Given the findings of this study midwives need to be aware that the socialising effects of the hospital can reduce the choices that midwives are able to provide because it inhibits their autonomous and independent fuctioning at a critical phase in their training.. Such functioning is expected in law and by the consumers. The idealism of students entering the profession needs to be supported and maintained if we are to achieve the goals first proclaimed by the Midwifery Act at the beginning of this century.

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APPENDIX A

SAMPLE of OBSERVATIONS

Themes / codes

Date: 8/7/88
Location: Labour Ward
Student: 13-N (Trained 9 months)

She rinses off the rest of the equipment and then takes off her gloves and washes her hands. N takes baby's temperature and Sr starts to write out the labels. N looks at the thermometer and says to baby "want you warmer than that"; puts the thermometer back under the baby's arm; "36.4"; she then gets the scissors and cuts the baby's cord after applying the cord clamp. She then wipes off the cut end. She washes her hands again and wraps the baby in a fresh warm blanket that she has brought in and she picks him up. Pt "Is he alright?" N "Just going to wash his head...let's have a look at you...ugh...pretty horrid isn't it?" N washes the blood off the baby's head with swabs and a small amount of water. Sr hands her a warm towel and she dries his head. She puts him back into the cot while she finishes drying him off. She then places the baby in another warm, clean blanket. Sr "Alright R - do you want to turn over this side?" (to where the baby is). Pt "No", says something inaudible. N checks the baby over without saying anything. Checks the head, ears, fingers -counts them aloud, looks in the axilla and groin and counts his toes. She checks his penis for hypo/hyperspadias and his testicles for descent. "Yes". She checks his hips and then turns him over and runs her finger down his spine. "Yep...weight?" Sr gets a sheet of paper for the scales and then balances them.

APPENDIX B

Interview Questions

1. When you are given information by a member of the staff do you have any difficulties with it? (prompt) too difficult? too advanced? not enough to be helpful? teminology?

2. Do you find your mentor / midwife checks what skills you can perform before leaving you to "get on with it?"

3. Do you get sufficient demonstration or teaching of skills? Or supervision of skills?

4. How do you feel about the use of technology in midwifery?

5. Do you think there is anything that interferes with staff teaching you?

6. Do you have an idea of what a midwife's role it? How do you think you obtained it? Do you find different people have different ideas on the role of a midwife? Can you give examples?

7. What is the best learning method for you when you are learning skills?

8. Do you think you get sufficient education or not? If not why not?

9. Do you have enough knowledge for each clinical placement?

10. Do you feel anxious in the clinical area? For what reasons?

11. Do you find everyone is interested in teaching you?

12. Do you feel the medical people affect your independence? How?

13. Is there anything about your program you would change if you had the opportunity?

APPENDIX C

Statistics of Case Study Site

	1987	Jan.- May 1988
No. of deliveries	4351	1840
No. of babies	4400	1966
Inductions	570	283
Epidurals	1929	746
Spontaneous cephalic	2714	1057
Breech delivery	36	36
Multiple delivery	35	35
Non rotation forcep	543	254
Rotation forcep	203	126
Ventouse	138	55
Total vaginal deliveries	3669	1547
Elective LSCS	276	119
Emergency LSCS	406	173
Total LSCS	682	292

PPH 0.6-1 litre	202	65
PPH > 1 litre	87	21
Total PPH	289	86
Stillbirths	17	7
Neonatal deaths(1 week)	12	6
Perinatal Deaths	29	13
Maternal Deaths	0	0

APPENDIX D

Consent for Participation in Research Study

Study Site

File Ref.:

RESEARCH ON MIDWIFERY
STUDENTS

Date:

I/we are willing to participate in a study of student's skills in midwifery at _____ Maternity Hospital. I understand that the study involves interviews and observations of me while I am caring for patients. I am willing for the researcher to look at my school file on the understanding that this information will be kept confidential. I understand that I may withdraw from the study at any time without detrimental effect on my status within the hospital/educational organization. I also understand that all information obtained from me by interview or through observation will be kept confidential by the researcher and my anonymity will be preserved.

SIGNATURES OF PARTICIPANTS

Form 00105

APPENDIX E

STUDENT GROUPS

Set A. Commenced midwifery training 1.3.87

Joanne D.O.B. 1964. Irish. Registered general nurse -1986. Trained in Ireland. Leaving certificate- 7 subjects. Staff nurse 6 months surgery.

Linda D.O.B. 1961. British. Registered general nurse -1986. Trained in England. G.C.E. '0' level - 6 subjects. 'A' level - 2 subjects. Additional training — Certificate in Tropical Medicine, Certificate in Parasitology, Certificate in Nutrition and Child Health. Experience — Volunteer nurse in Bombay, India. Primary health care nurse in Afghanistan and Pakistan. Staff nurse 10 months surgery, England.

Peggy D.O.B. 1963. British. Registered general nurse - 1986. Trained in England. G.C.E. '0' level - 6 subjects. Staff nurse 10 months gynaecology.

June D.O.B. 1961. Irish Registered general nurse - 1985. Trained in England. Leaving certificate 9 subjects, 3 with honours. Additional training - Professional development for newly registered nurses. Staff nurse 18 months.

Merril D.O.B. 1964. British. Registered general nurse - 1986. Trained in England. G.C.E. '0' level - 6 subjects. 'A' level - 2 subjects. Staff nurse 12 months.

Set B. Commenced midwifery training 30.8.87

Ida D.O.B. 1962. Irish. Registered general nurse 1984. Trained in Ireland. Leaving certificate 9 subjects. Staff nurse 2 years.

Ginny D.O.B. 1963. British. Registered general nurse 1986. Trained in England. G.C.E. '0' level 6 subjects. Senior staff nurse gynaecology 12 months.

Janet D.O.B. 1962. New Zealand. Registered general nurse 1985. Trained New Zealand. No information on education. Staff nurse 15 months neuro/dermatology.

Bronwen D.O.B. 1964. British. Registered general nurse 1986. Trained in England. G.C.E. '0' level 10 subjects. 'A' level 2 subjects. Staff nurse 7 months.

Myrtle D.O.B. 1961. British. Registered general nurse 1986. Trained in England. G.C.E. '0' level 9 subjects. 'A' level 3 subjects. Worked as nanny and aerobics teacher.

Set C. Commenced midwifery training 1.3.88

Maureen D.O.B. 1964. British. Registered general training 1986. Trained in England. G.C.E. '0' level 9 subjects. 'A' level 1 subject. Staff nurse 13 months.

Violet D.O.B. 1964. British. Registered general nurse 1986. Trained in England. G.C.E. '0' level 8 subjects. 'A' level 2 subjects. Staff nurse 14 months.

Mandy D.O.B. 1963. British. Registered general nurse 1986. Trained in Scotland. G.C.E. '0' level 8 subjects. 'A' level 2 subjects. Staff nurse 12 months.

Marion D.O.B. 1965. Irish. Registered general nurse 1986. Trained in Ireland. Leaving certificate 7 subjects. Staff nurse 8 months.

Fiona D.O.B. 1964. British. Registered general nurse 1986. Trained in England. G.C.E. '0' level 8 subjects. 'A' level 2 subjects. Staff nurse 16 months.

Set D. Commenced midwifery training 5.6.88.

Sarah D.O.B. 1963. Irish. Registered general nurse 1985. Trained in Ireland. G.C.E. '0' level 8 subjects. Staff nurse 8 months Ireland, 5 months Switzerland.

Florence D.O.B. 1964. Irish. Registered general nurse 1987. Trained England. G.C.E. '0' level 7 subjects. Staff nurse 11 months.

Mabel D.O B 1963 British. Registered general nurse 1988 Trained in England. G.C.E. '0' level 9 subjects. Staff nurse 11 months. Worked for social services 18 months prior to nursing.

Susan D.O.B. 1962. Trinidad. Registered general nurse 1987. Trained in Trinidad. G.C.E. '0' level 8 subjects. 'A' level 1. Staff nurse 11 months. Teacher 1980-83.

Jodie D.O.B. 1964. British. Registered general nurse 1986. Trained in England. G.C.E. '0' level 9 subjects. 'A' level 2. Staff nurse and Community sister.

Set E. Commenced training 1.9.88

Jean D.O.B. 1964. British. Registered general nurse 1986. Trained in England. G.C.E. '0' level 5 subjects. 'A' level 2 subjects. Staff nurse 18 months surgery.

Lynne D.O.B. 1966. British. Registered general nurse February 1988. trained in England. G.C.E. '0' level 7 subjects. Staff nurse 6 months trauma unit.

Roberta D.O.B. 1966. Irish. Registered general nurse 1988. Trained in Ireland. G.C.E. '0' level 6 subjects. Staff nurse 4 months.

Jackie D.O.B. 1964. British. Registered general nurse 1986. Trained in England. G.C.E. '0' level 8 subjects. 'A' level 2 subjects. Staff nurse 14 months.

Martha D.O.B. 1963. Australian. Registered general nurse 1987. Trained in Australia. High School Exam 5 subjects. Staff nurse 12 months.

APPENDIX F

GLOSSARY OF TERMS

apnoea monitor Electronic device to measure an infant's resiratory rate and to sound an alarm if breathing stops.

cardiotacograph (C.T.G.) External monitoring of fetal heart rate and uterine contractions by means of an electrode placed on the mother's abdomen.

decelerations See Type I dip.

epidural anaesthesia Local anaesthesia injected into the epidural space of the spinal canal to obliterate sensation and movement from the waist downwards.

Guthrie A blood test for genetic metabolic abnormalities (e.g. phenylketonuria) which is required by law on a newborn infant in the first week of life.

gyne Gynecology course.

mentor Midwife who is designated as responsible for the training and evaluation of a specified student while in a clinical area.

obs.. Observations of vital signs of a patient, including temperature, pulse rate, respiratory rate, blood pressure and fetal heart rate.

palpation Use of the hands to ascertain the size and position of the fetus in the mother's abdomen.

positions Placement of the fetal skull in the birth canal as determined by digital examination during labour.

positive pressure unit Automated device to assist breathing.

prostatin Medication administered by vagina to start labour.

radical midwives An association of midwives who challenge routine medical intervention and the medicalization of childbirth.

scalp clip A metal electrode which is attached to the fetal scalp duriing labour to monitor fetal heart rate.

S.C.B.U. Special care baby unit.

suction Aspiration of secretions from the nose and throat by means of a tube.

team midwifery A group of midwives who provide continuing care to women throughout their pregnancy, labour and postpartum terms.

Type I dip Deceleration of the fetal heart rate to less than 100 per minute occurring during a uterine contraction in labour.

Type II dip Deceleration of the fetal heart rate to less than 100 per minute occurring after a uterine contraction in labour.

vaginal examination (V.E.) Vaginal digital examination during labour for the assessment of the cervix and fetal head position in relation to the woman's pelvis.

APPENDIX G

Sample of Role Conflict and 'Trial and Error' Learning

Date: 8/7/88
Location: Labour Ward
Student 12-N (interview)

Themes/codes

"The practical side has to be taught to you doesn't it....by whoever's looking after you. They're not very hot on teaching. When things are quiet they are sitting in the office. I was sitting in the office with a book when a midwife asked me if there's anything I want to go over...that's not usual". I ask N about A.R.M.s and scalp electrodes. "So much to learn...learning things without being taught them. What you learn in school you put into practice. I've always been the type that asks loads of questions. I should think if you were quiet you wouldn't get to learn anything. Depends on who is in charge as to whether you learn things...some say get on and do it. On nights Sr said 'Well, you have a go'. Lots of time is spent with midwives who feel insecure if they aren't doing it...see themselves as 'the midwife in charge and therefore I should do it'. It's been good this time on the labour ward. They know I'm close to my finals. I haven't done much cos there's not been much to do...quiet...you do learn by trial and error...you just keep on doing it until you're told it's right or wrong. They get a bit petty in the end. You have to lay up your trolley one way for one person and another come along and says it should be different. I've been told so many ways to deliver the head that you have to decide which was is right for you".

APPENDIX H

Sample of Verbal Asepsis

Date: 13.9.88
Location: Labour ward
Student: 14-H

S/M then says "If we examine you, do you mind if we put a clip on the baby's head?" Pt "Why?" S/M "To monitor your baby". Pt "Will I have to lie down?" S/M "No, you can get up with it." H then goes to take pt's BP. Pt asks her to wait until after her contraction. S/M gets the V.E. trolley ready because pt had been complaining of "a full bowel sensation". S/M gets the internal electrode out of the machine and puts gel on it. S/M then explains what she is going to do. Pt "And where does this go?" indicating the electrode. S/M "Right here", and places it on her leg. Pt complains again of pressure on her bowels. S/M says "O.K." and she scrubs up. Pt "How does it attach?" S/M "Like a stapler". Pt "Does it damage the baby's head?" S/M "Oh no". S/M to pt "I will swab you down first it may be a little cold". Pt says she has a contraction. S/M "O K. I won't examine you while you are having a contraction. I will just swab you down." H watches to see when the contraction is finished and then S/M says "O.K.? Just some cold cream. I'm just trying to see where the baby is lying". Pt "The fontanelle?" S/M "Yes". H gets scrubbed up. S/M gets the scalp electrode ready while she stands with her hand in the pt. S/M puts on the electrode and then asks pt if she minds if H examines her. Pt asks what she is "or is H going to tell me?" S/M "Yes, H will tell you." H "Poor H - " laughs. Says to pt "Tell me if you get a contraction". H examines her. "Six - seven centimeters....a fair bit of cervix on the left". S/M "Do you mind of we talk over you?" Pt "No, I want to know". S/M "Now feel over to your right, in the corner — do you feel it?" H "Post — I'm not sure, really". She then Cleans up the pt and then the trolley.

APPENDIX I

Sample of Teaching Strategies

Date: 23/7/88
Location: Postnatal Ward
Student: 15-S

S "First week I felt I didn't get much support. First day I spend with a midwife who showed me two checks and then asked me if I felt alright to do them on my own. Then I was given a room and left to do it. No one checked whether I'd done a top and tail or a bath. I had to ask to be shown one..The midwife on tonight, she asked me where I was at in my training. I told her and she asked if I felt like looking after a ward. The other midwife laughed and said 'She's been doing it all week'. She was the only one to show an interest. There's been no effort from the staff to do any teaching or any little things. I'm now feeling more confident. The first week I felt I'd been thrown in. The first late I was on though...I rushed around to get my checks done. I didn't know that I had all evening. Most of them were done alright but I did rush them to get them done by 3:30. Prior to this midwife, no one had checked my checks...Nobody even knew that I'd done them. She made a conscious effort...she listened to me talking to other patients and then gave me pointers, told me what I should have said and what I did right. I watched her doing a breast feed. The way she held it...I found it quite helpful - it was different."

APPENDIX J

Sample of Maxims

Date: 20/6/88
Location: Labour Ward
Student 15-U

S/M comes back and calls U over to give her a hand. S/M to pt "Your boyfriend coming back for the delivery...is he hoping to?" Pt "No...I don't think my husband's going to get back in time". Pt "Got a contraction...do you want me to push?" S/M "Well, you don't look as if you have a desperate urge to push...I mean if you breathe through it...it will help the head to come down and save you pushing". S/M explains to U the external signs of fetal distress. "Can you pass the syntocin?" U passes it over and S/M breaks the ampoule and draws up the solution. She then comes around to look at the strip and explains to U "Some Type 2 decelerations, but this pattern (indicates one goes with the other) is normal in late first and early second stage....I think the contractions are much stronger than this shows." Pt gets a contraction and pushes. S/M "Oh...yes...the head's right there...can you see?" (to U) and explains to the patient what is happening. She tells her that U has to get ready so if she can slow down a bit "because it's her first time and I think this will be a quick delivery...just pop out". S/M to U " I'll just go and tell Sr W. because I think she will come and get the baby". Leaves. S/M comes back again. "Sr W. is going to get the baby...can you hang on...really strong, is it?" U goes to get ready.

APPENDIX K

Hours of Observations for Each Student Set

Set A		
Labour ward	—	12.0 hours
Postnatal ward	—	0.0 hours
Antenatal ward	—	9.0 hours
Antenatal clinic	—	4.0 hours
Community	—	0.0 hours
TOTAL	—	25.0 hours
SET B		
Labour ward	—	45.5 hours
Postnatal ward	—	12.5 hours
Antenatal ward	—	11.0 hours
Antenatal clinic	—	13.5 hours
Community	—	6.0 hours
S. C. Baby Unit	—	3.5 hours
TOTAL	—	92.0 hours
SET C		
Labour ward	—	33.0 hours
Postnatal ward	—	13.5 hours
Antenatal ward	—	8.0 hours
Antenatal clinic	—	10.0 hours
Community	—	0.0 hours
S. C. Baby Unit	—	5.5 hours
TOTAL	—	70.0 hours
SET D		
Labour ward	—	43.0 hours
Postnatal ward	—	10.5 hours
Antenatal ward	—	0.0 hours
Antenatal clinic	—	28.0 hours
Community	—	9.5 hours

TOTAL	—	91.0 hours
SET E		
Labour ward	—	25.0 hours
Postnatal ward	—	13.0 hours
Antenatal ward	—	8.0 hours
Antenatal clinic	—	10.0 hours
Community	—	0.0 hours
S. C. Baby Unit	—	5.5 hours
TOTAL	—	70.0 hours
TOTAL hours of Observation	—	344.0 hours
Labour ward	—	158.5 hours
Postnatal ward	—	49.5 hours
Antenatal ward	—	28.0 hours
Antenatal clinic	—	62.5 hours
Community	—	36.5 hours
S. C. Baby Unit	—	9.0 hours